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:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	03 September 2025
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0048143

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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 3 September 2025	15:45hrs to 21:20hrs	Rachel Seoighthe	Lead
Thursday 4 September 2025	07:25hrs to 14:00hrs	Rachel Seoighthe	Lead
Wednesday 3 September 2025	15:45hrs to 21:20hrs	Brid McGoldrick	Support
Thursday 4 September 2025	07:25hrs to 14:00hrs	Brid McGoldrick	Support
Wednesday 3 September 2025	15:45hrs to 21:20hrs	Kathryn Hanly	Support
Thursday 4 September 2025	07:25hrs to 14:00hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

This unannounced inspection was conducted over the course of an evening and one day. Inspectors spent periods of time, over the course of the inspection, observing staff and resident engagement. Many residents spoke very positively about the kindness of staff and the management team. Inspectors heard comments such as the staff 'could not be any more pleasant'. Alongside the general positive feedback, a resident also commented that staff turnover made it challenging to build relationships with new staff members. Several residents described occasions where they sometimes had to wait for long periods to be attended to, when they required assistance.

Inspectors were greeted by a member of staff on arrival at the centre. Following an introductory meeting with the management team, inspectors walked around the centre, giving an opportunity to review the living environment and to meet with residents and staff.

Located in the village of Moycullen, Co. Galway, An Teaghlach Uillinn Nursing Home is registered to provide care to a maximum of 53 residents. There were 50 residents living in the centre on the day of the inspection.

Inspectors spoke with 26 residents living in the centre. The majority of residents expressed satisfaction about the standard of care provided. Several residents' described their voice being listened to, when concerns were brought to the attention of staff and the person in charge. Residents' told inspectors that they could approach any member of staff, if they had any issue or problem to be solved. One resident told inspectors that the food was 'fabulous', but occasionally not hot enough, when served. The resident informed inspectors that they had raised this issue with the management, and they were satisfied with the action taken to address their concern. Residents' were complimentary of the food choices and homemade meals made on site by the kitchen staff. One resident expressed appreciation for the chef, noting that they especially enjoyed the pancakes that were made for them each evening.

Residents told inspectors that they felt safe in the designated centre and were aware of how they could raise a concern. Inspectors spoke with a number of staff during the inspection, who confirmed that they had attended safeguarding training. Staff described how they would support residents, in line with the designated centre's safeguarding policy.

Several residents expressed satisfaction with the improvement in the activity provision. The daily and weekly activity schedule was displayed in communal areas. Residents confirmed that there was a wide range of activities taking place, seven days a week. Group activities, led by activity co-ordinators, mainly took place in the large day room on the ground floor. On the first evening of the inspection, a large group of residents were seen enjoying live music in this room. Residents reported

that they had good access to allied health services, including physiotherapy, and two residents described how they had experienced improvements in their mobility, since coming to live in the centre.

While residents told inspectors that staff were kind to them, several had concerns about staffing levels in the centre, and how this impacted on their personal routines. Residents described occasions where they had to wait extended periods of time for staff to assist them with their care needs. One resident told inspectors that a delay in staff responding to their request for assistance on the first evening of the inspection, resulted in them attending to their own needs, which increased their own risk of falling. Another resident described having to wait for assistance with personal care. They told inspectors that 'there are a lot of new faces, and not very many around.' Inspectors observed several occasions during the inspection, where staff were unable to attend promptly to residents requests for assistance with personal care. Staff informed inspectors that they could not assist immediately, as they were supporting other residents with their care needs.

Inspectors observed a daily staff handover sheet, which detailed and directed staff about residents' specific care needs and any requirements for completion. The director of nursing undertook to include the continence needs of residents going forward.

The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs. Resident bedroom and communal accommodation was laid out over both floors, which were accessible by stairs and passenger lift. The first floor of the centre comprised the Lavender and Marigold units. It was registered to accommodate up to 10 residents, in shared and single bedrooms. The ground floor, which accommodated up to 43 residents, comprised four units; Primrose, Rose, Sunflower and Holly.

The majority of residents had personalised their bedrooms with photographs, ornaments and other personal memorabilia. Lockable storage space was available and personal storage space comprised of a bedside locker and wardrobes. The privacy and dignity of the resident's accommodation in the twin rooms was protected, with adequate space for each resident to carry out activities in private and to store their personal belongings.

There was a variety of communal spaces available to residents including dayrooms, dining rooms, a chapel and recreational room. Finishes, materials, and fittings in the communal areas and resident bedrooms struck a balance between being homely and being accessible, whilst taking infection prevention and control into consideration.

Overall, the general environment and residents' bedrooms, communal areas and toilets, bathrooms appeared appeared visibly clean. A schedule of painting work was ongoing, ensuring the centre was generally maintained to a high standard. However, areas of wall dampness were observed on Holly unit, resulting in paint deterioration and peeling.

Ancillary facilities generally supported effective infection prevention and control. The main kitchen was of adequate in size to cater for resident's needs. Toilets for

catering staff were in addition to and separate from toilets for other staff. There was also a sluice room on the ground floor for the reprocessing of bedpans, urinals and commodes. These areas were well-ventilated, clean and tidy.

However, the design of the housekeeping room and the onsite laundry did not support effective infection prevention and control. For example, the absence of a janitorial unit in the housekeeping room meant that mop buckets and chemicals were prepared within the sluice room. This practice posed a risk of cross contamination.

Conveniently located, alcohol-based product dispensers were readily available within bedrooms and on corridors. Upgraded clinical hand washing sinks had been installed in the sluice room and nurses station to support effective hand hygiene. These complied with current recommended specifications for clinical hand hygiene sinks. However, there was a limited number of dedicated clinical hand wash sinks within close proximity of resident bedrooms, and the sinks in the resident's bedrooms and ensuite bathrooms were dual purpose used by residents and staff.

Residents were encouraged and supported by staff to maintain their personal relationships with family and friends. Visitors were welcomed in the centre. Visitors were generally complimentary of the care provided to their relatives.

Information regarding advocacy services was displayed the centre, and inspectors were informed that residents were supported to access this service, if required.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations.

Capacity and capability

This was an unannounced inspection conducted 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 (as amended) and to follow up on the findings of the previous inspection in January 2025. The inspection also had a particular focus on the arrangements in place with regard to infection prevention and control following an outbreak of Carbapenemase-Producing Enterobacterales (CPE) in the centre. The provider had submitted an application to increase the occupancy of the centre. The details of this application were also reviewed on this inspection.

This inspection found that there was a new management team in place, who who were in the process of familiarising themselves with their roles and responsibilities, and in the process of developing governance and management systems to ensure a safe and consistent service. Inspectors found that the systems in place to supervise

care delivery, and monitor the quality and safety of care provided to residents, were not fully effective, as there were repeated findings in relation to compliance with regulations relating to individual assessment and care planning, protection, staffing, training, records and governance and management. Furthermore, infection prevention and control did not align with the requirements of the regulations.

This inspection found significant non-compliance in relation to Regulation 16: Training and staff development. The provider was required to submit an urgent compliance plan to the office of the Chief Inspector following this inspection, to give assurance that there were robust systems in place to appropriately supervise staff, so that all care was delivered in line with the resident's care plan, and records of care delivery were accurately maintained. The urgent compliance plan response submitted by the provider was accepted.

The designated centre is operated by Knegare Nursing Home Holdings Limited, who are the registered provider of An Teaghlach Uilinn Nursing Home. The registration of the centre was renewed in October 2024, with a reduced occupancy of 43 residents, due to an extended period of non-compliance with the regulations. Following an improvement in regulatory compliance found in January 2025, a subsequent application to increase the occupancy of the centre to 53 beds was granted by the Chief Inspector in July 2025. The registered provider used these beds for the purpose of providing a short-stay service on the first floor of the designated centre. The provider had submitted a further application to increase the occupancy of the first floor of the centre by 10 registered beds, prior to this inspection.

The management structure had changed since the inspection of the centre in January 2025. The person in charge was appointed in April 2025 and they worked full-time in the centre. An assistant director of nursing (ADON) deputised in the absence of the person in charge. A project manager, appointed in July 2025, was responsible for the coordination of short-term respite admissions in the centre. An operations manager worked full-time in the centre. Additional senior management support was provided by a director of operations, and a newly recruited clinical director who was a nominated person participating in the management (PPIM) of the centre. A team of nurses, health care assistants, household, activity, catering, administration and maintenance staff made up the staffing compliment.

At the time of inspection, there was a vacancy for one full-time clinical nurse manager (CNM). The provider informed inspectors that recruitment was ongoing to fill this post. The allocation of management resources at weekends was not clear. The registered provider informed inspectors that a senior nurse worked in a supervisory capacity at weekends, however this arrangement was not evident on rosters viewed. There were sufficient numbers of housekeeping staff on duty on the days of the inspection. However, rosters showed that the number of housekeeping staff was reduced at weekends, even though there was no evidence of any reduction in residents' needs. This arrangement did not ensure adequate cleaning staff resources were available each day, to ensure cleaning requirements were completed.

Inspectors found that the staffing number and skill mix on the day of inspection, were not appropriate to meet the care needs of the residents. Inspectors were informed that the provider had identified the requirements for an additional healthcare assistant to be rostered daily from 8am to 2pm. However, a review of rosters showed that this was not fully implemented at the time of the inspection. Furthermore, inspectors observed that staffing levels on the evening of the inspection did not allow for a timely response to residents' requests for assistance with their care needs.

Records demonstrated that staff had access to a varied training programme of education, including patient moving and handling, and safeguarding. A staff nurse was nominated to the role of infection prevention and control link practitioner, with the required training and protected hours allocated, to support staff to implement effective infection prevention and control, and antimicrobial stewardship practices within the centre. Staff were knowledgeable regarding the actions they would take in response to a safeguarding concern in the centre. Records demonstrated that the majority of staff had completed fire safety training, nonetheless, responses given by a small number of staff around fire safety procedures were not consistent. Furthermore, inspectors found that staff supervision was not robust. For example, supervision of pressure-related injury prevention and care was not robust, and posed a risk to the care of residents with impaired skin integrity. Repositioning records were incomplete for several residents with pressure-related injuries.

Some of the management systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. For example, systems of communication were not sufficiently robust. Inspectors found that separate clinical handovers took place on each floor. This arrangement posed a risk, as some staff were required to work on both floors during their shifts, and residents moved freely throughout the centre. This did not ensure that all staff had sufficient information regarding residents' care needs and potential risks; for example, risks relating to infection control. Furthermore, inspectors were informed that multi-disciplinary team meetings were convened weekly, relating to the care of residents admitted to centre for short-term respite and rehabilitative care. However, it was unclear how this communication system provided oversight of clinical care, as meeting records were not maintained.

There was an audit schedule in place to support the management team to measure the quality of care provided to residents. Inspectors viewed a sample of audits relating to infection control, call bell response times, and assessment and care planning. A review of records found that some audits were not used effectively to identify deficits in the service and drive quality improvement. For example, management meeting records evidenced discussion around increased in falls in late evening and early morning, and records showed that call bell response times were audited monthly. However, a review of completed audits demonstrated that call bell response were not audited at times when increased falls were identified, such as late evening. This incomplete information gathering impacted on the providers ability to appropriately monitor a potential risk, which may be a contributory factor to increased falls in the centre.

Prevalence of healthcare associated infection (HCAI) and multi-drug resistant organism (MDRO) colonisation was routinely recorded. However, this information was not routinely analysed to identify trends, detect increases in the incidence of infection, or recognise potential outbreaks early. Furthermore, disparities between the finding of local infection prevention and control audits and the observations on the day of the inspection (as detailed under Regulation 27) indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.

There were procedures in place to identify, assess, and record risks within the centre's risk register, with control measures developed to manage the impact of identified risks on residents. However, inspectors found that the actions taken to effectively manage or mitigate some risks was not effectively implemented. For example, there were risk assessments in place relating to residents who demonstrated exit-seeking behaviours. The completion of hourly safety checks was an established control measure, however, records showed that this measure was not fully implemented. Furthermore, there a risk assessment in place in relation to the risk of falls or self harm associated with openable first floor windows. Control measures were recorded as routine checks by staff to ensure windows are secure and not improperly opened. However, with the exception of checks recorded on 10 March 2025, there were no other checks available to view on the day of inspection and inspectors found that one first window was fully openable.

A review of the records kept in the designated centre found that action had been taken by the provider, since the last inspection, to ensure that records relating to staff were maintained in line with the requirements of the regulations. Staff personnel files contained the necessary information, as required by Schedule 2 of the regulations, including evidence of a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. However, inspectors found that some records were not maintained in line with the requirements of Schedule 3 of the regulations, as they were incomplete. This included records of nursing care provided to residents.

Regulation 15: Staffing

The number and skill mix of staff was not adequate to meet the needs of the residents taking into account the size and layout of the designated centre. This was evidenced as follows:

- There were occasions during the inspection where inspectors observed that staff were not able to respond immediately for residents requests for assistance. For example, some residents were required to wait for up to twelve minutes for the assistance with personal and nutritional care needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were not appropriately trained in relation to fire safety. There were inconsistent responses given by a small number of staff, as to the procedure to follow in the event of a fire in the centre. This could cause a delay in safely evacuating residents.

The registered provider did not have appropriate staff supervision arrangements in place, to ensure that care delivery was appropriately monitored and delivered. For example;

- There were gaps in the completion of safety checks for residents who had supervision needs.
- Supervision and monitoring of pressure related injury prevention and care was not fully effective, and posed a risk to the care of residents with impaired skin integrity. Repositioning records were incomplete for several residents with pressure related injuries.
- Inspectors observed the inappropriate use of hoist slings and pressure relieving mattresses in place for some residents, which may contribute to the development of, or the deterioration of existing pressure related injuries.

An urgent compliance plan was request following this inspection, to give assurance that there are robust systems in place to appropriately supervise staff, so that all care is delivered in line with the resident's care plan, and records of care delivery are accurately maintained.

The urgent compliance plan was accepted.

Judgment: Not compliant

Regulation 21: Records

The management of records was not aligned with the requirements of the regulations. For example:

- Records of nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example: records of repositioning charts for residents at high risk of impaired skin integrity were not maintained in line with the residents care plan.
- Records of hourly safety checks for residents with exit seeking behaviours were not maintained in line with the residents risk assessments.

- Records of checks of pressure relieving equipment were not maintained to ensure that the settings were appropriate for the residents weight.

Judgment: Substantially compliant

Regulation 23: Governance and management

A review of the staff available to work in the centre found that staffing resources were not in line with the centre's statement of purpose. There was a vacancy for one full-time clinical nurse manager, and records showed that there were inadequate house-keeping staff resources available each day, to ensure cleaning requirements were completed.

Some management systems were insufficiently robust to ensure the service provided was safe, appropriate and effectively monitored. For example:

- There was inadequate management oversight of staff supervision, records and infection control.
- The system in place to manage risk was not effectively utilised. Known risks were documented, however, the controls in place to manage some risks were not effectively implemented.
- The system in place to monitor incidents and ensure learning from adverse incidents was not effective. For example, the documentation relating to unexplained injuries was did not provide assurance that all possible factors relating to several incidents had been explored, to rule out potential safeguarding concerns.

Judgment: Not compliant

Quality and safety

Residents living in the centre were generally satisfied with the quality of the care they received and they expressed that they felt safe in the centre. Residents had timely access to general practitioners (GPs), allied health professionals, specialist medical and nursing services. Residents voiced high levels of satisfaction with the programme of activities and the choice and quality of food available. While the provider had taken action to address issues identified on the last inspection with regard to residents rights', individual assessment and care planning and protection, did not align with the requirements of the regulations. Furthermore, the provider did not met the requirements of Regulation 27: Infection control, and the National Standards for infection prevention and control in community services (2018).

Resident care plans were accessible on a computer-based system. Comprehensive assessments were completed for residents on, or before, admission to the centre. Care plans based on assessments were completed no later than 48 hours after a resident's admission to the centre and reviewed at intervals not exceeding four months. However, inspectors found that a number of assessments recorded did not reflect the residents' current condition, and some care plans contained information that did not reflect the residents' current needs and therefore could not guide care effectively. For example, a review of daily care progress notes demonstrated that a resident had compromised skin integrity following a hospital admission. However, a reassessment of the residents' skin integrity had not been completed and the care plan in place did not reflect the residents current care needs, described to the inspectors. This is detailed further under Regulation 5: Individual assessment and care plan.

The provider had measures in place to safeguard residents from abuse. The provider acted as pension agent for four residents and pensions were paid into a separate resident bank account. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were in place for all staff. A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff who spoke with inspectors demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse. However, records of preliminary screening investigations were not completed for several residents with unexplained injuries, to rule out any potential safeguarding concerns.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, staff applied standard precautions to protect against exposure to blood and body substances during handling of waste and used linen. The overall premises were designed and laid out to meet the needs of the residents. The general environment including residents' bedrooms, communal areas and toilets appeared visibly clean and well-maintained with some exceptions. The provider had a Legionella management programme in place. Water samples were routinely taken to assess the effectiveness of local Legionella control measures. Equipment was also generally clean with a few exceptions. For example; the underside of a small number of shower chairs were stained and a small number portable fans were dusty. Disposable privacy curtains within two bedrooms had not been changed within the previous three months or after these bedrooms were deep cleaned.

An outbreak of Carbapenemase-Producing Enterobacterales (CPE) colonisation was ongoing at the time of the inspection. The person in charge was engaging with Public Health regarding the management of this outbreak and had implemented all recommended controls to ensure the safety and well-being of residents, staff and visitors. Staff spoken with were knowledgeable of CPE infection prevention and control measures. However, the response to a potential simultaneous outbreak of acute respiratory infection (ARI) was less robust. Approximately 20% of residents had developed symptoms of respiratory infection in the previous week. However, a potential acute respiratory infection (ARI) outbreak was not detected and managed in a timely manner. Findings in this regard are presented under Regulation 27.

The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document contained details of health-care associated infections and colonisation to support sharing of, and access to, information within and between services.

Residents had access to timely health care from their general practitioner (GP) and to allied health professionals who attended the residents in the centre as necessary.

Residents had access to television, radio, newspapers and books. Religious services and resources were also available. A programme of activities was available to residents which included arts and crafts, living music and outings. There was an independent advocacy service available and details regarding this service were displayed in the centre. Residents' meetings were convened regularly to ensure residents had an opportunity to express their concerns or wishes.

Regulation 25: Temporary absence or discharge of residents

A review of documentation found that when residents were transferred to hospital from the designated centre, relevant information was provided to the receiving hospital. Upon residents' return to the designated centre, staff ensured that all relevant clinical information was obtained from the discharging service or hospital. Copies of transfer documents were filed in the residents charts.

Judgment: Compliant

Regulation 27: Infection control

The provider did not met the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018). For example;

- A potential acute respiratory infection (ARI) outbreak was not detected and managed in a timely manner. For example, the Public Health were not notified of the potential outbreak when the initial five residents first presented with respiratory symptoms within the same 48 hour period. While the majority of residents had received COVID antigen testing, there was no evidence that PCR testing for influenza, COVID and RSV testing was undertaken in line with national guidance. Furthermore, general outbreak control measures such as active surveillance, staff were not universally wearing masks when providing care and enhanced cleaning measured were not implemented. The failure to respond to the potential outbreak in line with local guidelines impacted effective infection prevention and control within the centre and may have contributed to onwards transmission.

- Several care plans, for residents that were colonised with CPE, advised the routine application of standard and contact precautions. This contradicted local guidelines which advised that standard infection control precautions were sufficient.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- There was a limited number of dedicated clinical hand wash sinks in the centre and the sinks in the resident's rooms and en-suite bathrooms were dual purpose used by residents and staff. A small number of staff told the inspector that used wash-water was emptied down sinks in resident bedrooms after assisting residents with personal hygiene. This practice increased the risk of environmental contamination and cross infection and was further compounded by staff using the same sink for hand hygiene.
- Ancillary facilities including the housekeeping room and laundry did not support effective infection prevention and control. There was no janitorial unit within the housekeeping room. Housekeeping buckets were emptied within sluice rooms which posed a risk of cross contamination. The infrastructure of the on-site laundry did not support the functional separation of the clean and dirty phases.
- Damp on the walls in Holly unit had caused peeling paint. Signs of water damage were also observed. Peeling paint and damp surfaces can promote mold, dust and micro-organisms.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of resident files and found that individual assessment and care planning was not in line with the requirements of Regulation 5. Several care plans reviewed did not contain up-to-date information, to direct staff regarding the interventions required to ensure residents' care needs were met. For example:

- An up-to-date MDRO colonisation status was not recorded in one resident's care plan.
- A resident who had experienced significant weight loss did not have an accurate nutritional risk assessment completed to inform their nutritional care plan. Consequently, the care plan did not detail the interventions necessary to support residents with their nutritional care needs
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan for a resident with compromised skin integrity did not reflect the specific nursing interventions required to specifically manage those needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP), and GPs were visiting the centre, as required.

Residents had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life, and palliative care.

Judgment: Compliant

Regulation 8: Protection

While the provider had taken steps to protect residents from abuse, including training and the provision of a safeguarding policy, records of preliminary screening investigations into several potential safe-guarding concerns were not available to review.

Judgment: Substantially compliant

Regulation 9: Residents' rights

In the main, residents rights' were upheld. This was evidenced by the improved schedule of activities provided which residents confirmed satisfaction with. Residents reported enjoying the recent visit by puppy and were looking forward to the upcoming celebration of world physiotherapy day.

Residents were facilitated to provide feedback in relation to the service.

Residents were provided with information about services available to support them, such as independent advocacy 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	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0048143

Date of inspection: 04/09/2025

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Since the inspection, a review of staffing levels and deployment across all shifts has been undertaken. As a result, staffing rosters have been adjusted to ensure additional coverage during peak periods of resident care needs. To support both morning and evening care routines, an additional morning shift has been introduced, and a later finishing time has been added to the evening shift, providing increased hands-on support during peak care times. Care team allocation and skills mix rostering is now completed based on the dependency levels of residents residing in the centre, using an approved dependency assessment tool. This will ensure that staffing resources and skill mix are appropriately aligned with residents' assessed care needs and support requirements. The Person in Charge will monitor the effectiveness of these actions taken to ensure that residents' requests for assistance are met promptly by undertaking regular review of call-bell response data, and ongoing collection and analysis of resident feedback in resident's meetings and satisfaction surveys. Findings will be reviewed weekly by the local management team, and any emerging trends or delays will trigger corrective action through on the ground supervision.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
All staff have completed updated fire safety training, including practical evacuation drills and competency checks to ensure understanding of procedures.

Enhanced supervision arrangements are now in place. The PIC, ADON and CNM complete daily walk-arounds and spot checks to ensure care delivery, safety checks, and equipment use are in line with residents' care plans. A supernumerary nurse is rostered at weekends to maintain oversight.

All residents with pressure-related injuries have been reviewed by the Tissue Viability Nurse (TVN), and care plans, repositioning charts, and hourly safety checks are now completed and audited for accuracy.

Staff have been re-educated on documentation, equipment use, and pressure injury prevention.

Audits confirm improved compliance, and governance meetings continue to monitor outcomes to sustain full compliance with Regulation 16.

Further details are provided under Regulation 21: Records.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Following the inspection, a comprehensive review of all resident care records was undertaken to ensure documentation accurately reflects the care provided. The following corrective actions have been implemented:

• All residents identified as being at risk of impaired skin integrity are clearly highlighted on the daily handover sheets for both nursing and healthcare staff. This ensures that staff are aware of those residents requiring increased monitoring and scheduled repositioning.

All residents assessed as being at high risk of impaired skin integrity now have repositioning charts completed in accordance with their individual care plans. These charts are reviewed by nursing staff on each shift and signed off by the Clinical Nurse Manager (CNM) or Assistant Director of Nursing (ADON) daily to confirm compliance.

• Residents identified as being at risk of absconsion or exit-seeking behaviours will be clearly highlighted and flagged to all staff through individual risk assessments, handover reports, and daily safety briefs.

This ensures that staff are fully aware of residents requiring hourly safety checks in

accordance with their assessed needs.

All staff have been reminded of the importance of completing and recording these checks accurately and contemporaneously. The Clinical Nurse Manager (CNM) will verify that the hourly safety check records are completed in line with residents' risk assessments during daily walk-arounds and will address any omissions immediately.

• A standardised checklist has been introduced for verification of pressure-relieving equipment. This includes documentation of equipment type, pressure setting, and confirmation that the setting is appropriate to each resident's current weight. These checks are reviewed and initialled by nursing staff and checked by the Person in Charge.

The importance of contemporaneous documentation and accountability has been reinforced through supervision and toolbox talks.

The Person in Charge will monitor compliance of all records through:
• Monthly audits of repositioning, safety, and equipment check records;
• Random spot-checks of documentation at shift handover;
• Review of incident trends and feedback from staff and residents.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In response to the inspection findings, staffing and governance arrangements have been strengthened to ensure the safe and effective delivery of care.

A full-time Clinical Nurse Manager (CNM) commenced employment on 16 September 2025.

Housekeeping hours for the upstairs unit have been corrected, with four hours now allocated daily, including weekends.

Management oversight has been enhanced. Managers' hours have been revised to provide greater visibility and supervision throughout the day and evening, and weekend management shifts are now rostered at least once per month. Daily walk-arounds, spot checks, and weekly governance audits are conducted by the Person in Charge (PIC), ADON, and CNMs to monitor staff supervision, documentation, infection control, and environmental hygiene.

Risk management and incident review systems have been reviewed to ensure robust oversight. All suspected safeguarding concerns, including unexplained injuries, are now reported immediately to the assigned Safeguarding Officer and investigated by the

Clinical Management Team. Where unexplained injuries occur, a safeguarding incident record is created, care plans are reviewed or adjusted, and appropriate actions are documented.

Follow-up reviews are undertaken, and learning from incidents is shared through staff meetings, discussions with residents or their representatives, and announcements via the Strandum system.

Where safeguarding concerns are identified, they are reported promptly to the HSE Safeguarding Team and HIQA via the relevant portals. All causes identified through review result in appropriate staff retraining, adjustments to practice, or enhanced care plans.

Ongoing governance meetings review audit results, incident trends, and staffing levels to ensure sustained compliance and continuous improvement.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Following the inspection, immediate corrective actions were implemented. The potential acute respiratory infection outbreak was reviewed in consultation with Public Health, and revised procedures have been introduced to ensure all future outbreaks are promptly identified, escalated, and managed in line with national guidance.

All staff have received refresher training on outbreak recognition, notification procedures, and the use of PPE, including the universal wearing of masks during outbreaks.

Enhanced cleaning schedules and active surveillance protocols are now in place.

Care plans for residents colonised with CPE have been reviewed and updated to reflect current HSE and local infection control guidance.

Environmental improvements have commenced. The suitability of areas for the installation of clinical hand wash sinks is currently under review, and staff have been re-educated that resident sinks must not be used for the disposal of waste water or for hand hygiene purposes.

The housekeeping and laundry areas are being reconfigured to ensure functional separation of clean and dirty zones, and a dedicated janitorial unit has been ordered for installation in the housekeeping room.

Damaged surfaces and areas of dampness in Holly Unit are being repaired and repainted with washable, infection-control compliant materials.

Ongoing infection control audits are now conducted monthly by the Person in Charge and Infection Prevention and Control (IPC) Link Nurse, with findings reviewed at governance meetings.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Following the inspection, a full review of all residents' assessments and care plans was completed to ensure they contain current, accurate, and relevant information to guide care delivery.

The care plans referenced during the inspection have now been updated to accurately reflect each resident's assessed needs, including MDRO colonisation status, nutritional risk, and skin integrity management interventions.

The Assistant Director of Nursing (ADON) and Clinical Nurse Manager (CNM) will monitor any changes in residents' conditions — such as weight loss, infection status, or skin deterioration — identified through information provided at morning handovers, multidisciplinary team (MDT) reports, and residents' presentation. Where a change is identified, a reassessment and update of the relevant care plan will be completed immediately to ensure that interventions remain appropriate and responsive to the resident's needs.

All nursing staff have received refresher toolbox talks on the requirements of Regulation 5, documentation standards, and the importance of timely and accurate care-plan updates.

To support consistent compliance, monthly audits of residents' care plans are being conducted by the ADON and CNM. Audit findings are discussed at governance and management meetings, and any deficits identified are addressed promptly. The outcomes of these audits, along with resident feedback, inform ongoing quality improvement initiatives within the centre.

The Person in Charge (PIC) will monitor the effectiveness of these actions through:
• Ongoing audits of resident care plans and associated risk assessments
• Analysis of audit trends and corrective actions discussed at management meetings.
• Feedback from residents and staff regarding the responsiveness and accuracy of care planning.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
A full review of all safeguarding documentation and processes has been completed to identify any gaps in record-keeping or file accessibility.

A revised safeguarding documentation and record management system has been implemented to ensure that:
• All preliminary screenings and related correspondence are documented, dated, and securely stored within residents' safeguarding files on the Centre's Clinical Management System
• Records are easily retrievable for internal and external review, including by inspectors and safeguarding teams.
• A tracking log is maintained to monitor the progress and outcome of each safeguarding concern.

The Person in Charge will review incident and safeguarding files monthly to ensure compliance and report findings at the governance and management meeting.

Resident feedback and any safeguarding-related notifications will also be monitored to ensure that all concerns are appropriately documented and managed.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/11/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	10/09/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	21/11/2025
Regulation 23(1)(a)	The registered provider shall	Substantially Compliant	Yellow	01/11/2025

	ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	01/11/2025
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	30/12/2025
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	Substantially Compliant	Yellow	30/11/2025

	immediately before or on the person's admission to a designated centre.			
Regulation 5(4)	The person in charge shall formally review, at 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.	Substantially Compliant	Yellow	30/11/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/10/2025