



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Shannon Lodge Nursing Home
Name of provider:	Shannon Lodge Nursing Home Rooskey Limited
Address of centre:	Main Street, Rooskey, Roscommon
Type of inspection:	Unannounced
Date of inspection:	26 February 2026
Centre ID:	OSV-0000383
Fieldwork ID:	MON-0049612

About the designated centre

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

Shannon Lodge Nursing Home is a purpose-built bungalow-style facility located in the village of Rooskey, Co. Roscommon. It is a short drive from the N4 Dublin-Sligo road and a fifteen-minute drive from the town of Mohill. The centre provides care for 36 residents with a range of care needs from low to maximum. The nursing home is organised over two levels. All resident accommodation is on the ground floor, and the upper floor is allocated to office space and staff facilities. Residents' bedroom accommodation is comprised of 18 single and nine double rooms. The provider employs a staff team consisting of registered nurses, care assistants, housekeeping, catering and activity staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	29
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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
Thursday 26 February 2026	09:00hrs to 17:00hrs	Michael Dunne	Lead
Thursday 26 February 2026	09:00hrs to 17:00hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

There was a relaxed atmosphere within the centre, as evidenced by residents moving freely throughout the centre. Staff were seen to be responsive, and attentive without any delays in attending to residents' requests for support. Throughout the day, inspectors observed many residents engaging in good-natured banter, chatting, laughing, and interacting comfortably with staff, and with each other. Residents appeared relaxed in the company of staff, observations found numerous interactions, and shared moments of fun, and companionship between residents, and staff. Residents who shared their views with the inspectors said that they were looked after very well by a staff team who were kind, and considerate. One resident said " all the staff are on the ball, and know how to look after us".

While the centre generally provided a comfortable, and homely environment for residents, additional focus is required in respect of premises, and infection prevention, and control, which are interdependent. For example, inspectors observed that the décor in the centre was showing signs of minor wear, and tear. Surfaces and finishes, including wall paintwork, and flooring in some resident rooms, and communal areas, were worn. The provider was endeavouring to improve existing facilities, and physical infrastructure at the centre through ongoing maintenance, and renovations. Despite the infrastructural issues identified, overall the general environment, and residents' bedrooms, communal areas, toilets, and bathrooms inspected appeared visibly clean.

The majority of residents had personalised their bedrooms with photographs, ornaments, and other personal memorabilia. There was sufficient secure storage space available, and personal storage space comprised of bedside lockers, and wardrobes. The privacy and dignity of the residents' accommodation in the twin-occupancy rooms were protected, with adequate space for each resident to carry out activities in private, and to store their personal belongings within easy access.

There were arrangements in place for the laundering of residents' clothing, and the laundering of used linen was provided by an external contractor, while some residents chose to have their clothing laundered at home. Clothes were marked to ensure they were safely returned from the external laundry.

The main kitchen was of adequate in size to cater for residents' needs. Toilets for catering staff were in addition to, and separate from toilets for other staff. However, the design of the housekeeping, and sluice rooms did not support effective infection prevention and control practices. For example, in the absence of a janitorial unit in the housekeeping room meant that mop buckets were prepared within the sluice room. This practice posed a risk of cross contamination. Details of issues identified are set out under Regulation 17.

Conveniently located, alcohol-based product dispensers were readily available within bedrooms, and on the corridors. Two upgraded clinical hand-washing sinks had been installed on the corridor to support effective hand hygiene. These complied with current recommended specifications for clinical hand hygiene sinks. However, the sinks located in the sluice room did not comply with these specifications.

The activity coordinator organised the weekly social activities, and entertainment programme. This person demonstrated a commitment, and enthusiasm for their role. Residents confirmed that they could choose to socialise, and participate in activities, and there was a varied and flexible activities schedule provided seven days of the week. Many of the residents spent their day between the two main lounges, where they were observed reading newspapers, watching TV, and participating in activities such as physical exercise to music, and topical discussions.

Residents were very complimentary of the home cooked food, and the dining experience in general. Inspectors were informed that breakfast started at 7am, and continued until late morning. This supported residents' choice, and independence by accommodating individual routines, preferences, and sleep patterns. There were adequate numbers of staff available to assist residents at meal times. Inspectors observed residents being assisted with their meals in a respectful, and dignified manner. Options available for residents on the day of the inspection consisted of lasagne or a sweet, and sour option. Residents confirmed that should they not like what was on the daily menu, the catering staff would provide an alternative meal to their liking.

The next two sections of the report, capacity and capability and quality, and safety will describe the provider's levels of compliance with the Health Act 2007 and the Care, and Welfare Regulations 2013. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), to inform the application to renew the registration of the centre, and to follow up on the findings of the previous inspection of April 2025. This inspection also had a specific focus on the provider's compliance with infection prevention, and control oversight, practices, and processes.

Findings of this inspection were that the registered provider did not adequately address current management systems to identify, and monitor the quality, and safety of care provided to residents, in particular with regard to documentation, care planning, and infection prevention and control. The issues of concern are detailed further under the relevant regulations.

Inspectors reviewed the provider's progress with completion of the actions detailed in the compliance plan from the last inspection, and found that the majority of actions outlined had been addressed, although some additional concerns in relation to infection prevention, and control were identified on this inspection.

The registered provider ensured that sufficient resources were available to allow a high level of care to be provided to the residents. There is a well-defined, and stable management structure in place with identified lines of accountability, and authority. The person in charge (PIC) worked full-time in the centre, and is supported in the role by a clinical nurse manager (CNM), preceptor, and a team of nurses, healthcare assistants, housekeeping, activities, administration, maintenance, and catering staff. On the day of inspection, there were sufficient staffing levels, and an appropriate skill-mix to meet the assessed needs of the residents.

There was an ongoing schedule of training in the centre, and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and the training was up to date. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding of vulnerable adults, and infection prevention and control. Staff were clear about their roles, and the standards that were expected of them in their work. Staff said they were well-supported, and that they had good access to training and updates. Staff demonstrated appropriate knowledge, and skills in their day-to-day work.

There were established recruitment processes in place, and all staff files reviewed contained An Garda Síochána vetting as well as the other requirements of Schedule 2 of the regulations. The inspectors reviewed three resident contracts. The contracts reviewed contained all of the information required by Regulation 24: Contract for provision of services.

Amendments were required to the statement of purpose submitted by the provider, in support of the renewal of the centres' registration. These included an accurate account of the services provided in the centre, and the number of staff available to deliver this service. The provider submitted an updated statement of purpose following the inspection to meet the requirements of the regulations.

There were processes, and systems in place to monitor the quality of the service on an on-going basis. These included the monitoring of key performance indicators such as falls, wound care, infections, and restrictive practices. While the majority of audits were providing information the provider was using to improve the quality of the service, some audits were not identifying areas that required additional focus. While staff were monitoring antimicrobial consumption monthly, this information was not routinely analysed to identify trends, detect increases in the incidence of infection or recognise potential outbreaks early. Documentation reviewed indicated that an acute respiratory infection outbreak in December 2025 had gone undetected. This is discussed further in the quality and safety section of this report.

A review of records found that the respiratory outbreak mentioned above, which impacted 13 residents was not notified to the office of the Chief Inspector of Social

services in line with the regulations. While the provider maintained a number of assurance processes in relation to the standard of environmental hygiene, which included cleaning checklists, and color-coded cloths and mops, to reduce the chance of cross infection. A lack of consistent oversight of deep cleaning records reduced the ability of management to verify that cleaning standards were consistently met.

The provider maintained a policy, and procedure on complaints. Records confirmed that the provider investigated complaints in line with this policy. One complaint, and one concern were recorded since the last inspection, and were seen to be resolved within the specified timescale as outlined in the complaints policy. The provider was keen to learn from complaints, and to identify patterns that may impact on the quality of the service provided.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had submitted an application to renew the registration of the centre prior to the inspection visit. In addition to the application to renew the registration, the provider also submitted all the required information to comply with Schedule 1, and Schedule 2 of the registration regulations.

Judgment: Compliant

Regulation 15: Staffing

Through a review of staffing rosters and the observations of inspectors, it was evident that the registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

There was an on-going schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. Records reviewed showed the majority of staff had completed training in safeguarding of vulnerable persons from abuse, fire safety training, manual handling and infection prevention and control.

Judgment: Compliant

Regulation 23: Governance and management

The governance arrangements in relation to infection prevention and control, and antimicrobial stewardship did not ensure the sustainable delivery of safe, and effective infection prevention. For example;

- Improved oversight of the systems in place to ensure that potential outbreaks are detected and managed in a timely manner.
- The antimicrobial stewardship programme did not ensure that quality improvement initiatives were identified and implemented.
- The management systems of oversight process for ensuring all areas of the home were regularly deep cleaned was not sufficient. Deep cleaning schedules and records made available, did not provide sufficient assurance that every bedroom and areas of the centre was deep cleaned every month or as required thereafter.
- The oversight process for submitting notifications, within the required time frames, as set out in the regulations was not effective.
- Measures in place to ensure the statement of purpose was updated in line with Schedule 1 of the regulations were not efficient.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A review of a number of contracts for the provision of services confirmed that residents had a written contract of care that outlined the services to be provided, and the fees to be charged, including fees for additional services.

Judgment: Compliant

Regulation 3: Statement of purpose

Although there was a statement of purpose in place this document required updating to accurately describe the following:

- An accurate description of the services that are provided to meet the assessed needs of the residents, for example, the current arrangements in place for residents to access primary care services.

- The number of WTE (whole-time equivalents) of staff allocated to both the activity support and housekeeping roles.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The Chief Inspector was not notified of suspected outbreaks of infection involving two or more residents who were displaying signs of infection. This was identified from the records reviewed, and from talking to staff, that these infections had occurred in December 2025.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members to lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated, and details on the appeal process should the complainant be unhappy with the investigation conclusion. A review of the complaint's register indicated that the provider had managed the complaints in line with the centre's complaints policy.

Judgment: Compliant

Quality and safety

Overall, inspectors observed that residents living in the centre enjoyed a good quality of life. There was a rights-based approach to care; both staff, and management promoted and respected the rights, and choices of residents living in the centre. Residents lived in an unrestricted manner according to their needs, and capabilities. There was a focus on social interaction led by staff, and residents had daily opportunities to participate in group or individual activities. There were, however a number of areas where there was a need for an additional focus to deliver a safe, and consistent service. In particular, these issues are discussed under regulations relating to care planning, and infection prevention and control.

Residents had access to appropriate medical, and specialist healthcare to support their needs. Residents had timely access to their general practitioners (GPs), and other health, and social care professionals such as physiotherapy, speech, and language therapy, dietitian, and chiropodist. Inspectors were informed that all residents had recently received a dental checkup.

Residents' care plans were accessible, and made available for inspectors to review. 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 the resident's admission to the centre, and reviewed at intervals not exceeding four months. However, on balance, the standard of oversight of the care planning did not ensure that they were concise, and guided effective care. For example, some residents had a large number of care plans, with many containing duplicated information across multiple plans. Fragmented documentation had the potential to result in omissions, miscommunication, and inconsistent care delivery. Details of issues identified are set out under Regulation 5: Individual assessment, and care plan.

Effective information, and communication systems supported a smooth transition for temporary absence or discharge of residents to the hospital. For example, a local transfer document contained the priority information required to give a clear picture of residents' transfer to the hospital. When residents returned to the designated centre, all reasonable steps were taken to ensure that relevant medical information was obtained from the discharging hospital.

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 few exceptions. The provider was endeavouring to improve existing facilities, and physical infrastructure at the centre through a planned 14-bedroom extension to the existing building. Efforts had been made to de-clutter the centre. However, there was a lack of storage space in the centre, resulting in the inappropriate storage of equipment in some areas of the centre. Findings in this regard are presented under Regulation 17: Premises.

The provider had taken precautions against the risk of fire in order to protect residents in the event of a fire emergency. A number of records relating to fire safety were found to be well-maintained. These records included, maintenance of the fire alarm system, certificates of servicing, and records that confirmed quarterly checks on emergency lighting, and on fire extinguishers. The provider maintained, and updated residents' personal emergency evacuation plans (PEEPs), which were updated at least every four months or as, and when residents' mobility needs changed. There were also records to confirm fire drills, and simulated evacuations were being conducted by the provider. Upgrades to fire doors, and fire signage were found to have been completed by the provider.

The provider had maintained good levels of communication with residents, ensuring that they were kept up-to-date regarding key events in the centre. Residents' meetings were informative, and covered topics such as resident care, food and catering, resident activities, and infection prevention and control issues. In addition,

to the structured residents' meetings the provider kept residents informed either verbally or through regular written communication in the form of a newsletter.

Residents' right to privacy, and dignity were respected, staff were observed to knock on residents' doors prior to entry, and explain the purpose of their visit. There were opportunities for residents to engage in the activity programme in-line with their interests and capabilities. Residents were seen to engage in planned activities throughout the day, while other residents pursued their own individual interests either in communal areas or in their own rooms.

There was a clear safeguarding policy in place that set out the definitions of the terms used, the responsibilities for different staff roles, the types of abuse, and the procedure for reporting abuse when it was disclosed by a resident, reported by someone, or observed. The management team were clear on the steps to be taken when an allegation was reported. The staff team had all completed relevant training, and were clear on what may be indicators of abuse and what to do if they were informed of or suspected abuse had occurred.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, staff were observed to apply basic infection prevention, and control measures known as standard precautions to minimise risk to residents, visitors, and their co-workers, such as hand hygiene, appropriate use of personal protective equipment, safe handling, and disposal of used linen.

Notwithstanding, the good practices observed, inspectors identified a small number of areas that required review to ensure that the registered provider complied with the national standards for infection prevention and control published by HIQA. For example, the response to an outbreak of acute respiratory infection (ARI) was not robust. Approximately 30% of residents had developed symptoms of respiratory infection in late December 2025. While the timing, and clinical presentations met the case definition of an ARI outbreak, Public Health and Infection Prevention and Control guidance on the prevention and management of cases, and outbreaks of respiratory viral infections were not implemented.

The Department of Public Health were not notified of the potential outbreak when five residents first presented with respiratory symptoms within the same 48-hour period. Inspectors were informed that the majority of residents had received COVID antigen testing; however, there was no evidence that PCR ((Polymerase Chain Reaction) testing for influenza, COVID, and RSV (Respiratory Syncytial Virus) testing was undertaken in line with National Guidance. Furthermore, general outbreak control measures such as twice daily active surveillance for symptomatic residents, isolation of symptomatic residents, universal wearing of masks when providing care, and enhanced cleaning measures were not implemented. This meant that the risk of further infection spread within the centre was not well managed.

Inspectors also identified that some aspects of equipment, sharps, and waste management did not comply with the national standards for infection prevention, and control published by HIQA. In addition, some housekeeping procedures did not follow best practices to eliminate the double-dipping of mops into used water.

Findings in this regard are presented under Regulation 27: Infection prevention, and control.

Regulation 11: Visits

There were no visiting restrictions in place, and visitors were observed coming, and going to the centre on the day of inspection.

Judgment: Compliant

Regulation 17: Premises

The premises generally met the needs of the needs of the residents, however, some areas for improvement were identified, including:

- A lack of appropriate storage space in the centre resulting in the inappropriate storage of moving, and handling equipment, cleaning equipment, and mattresses in various areas of the centre.
- A review was required of furniture, such as armchairs, to ensure they were in a good state of repair, and could be cleaned effectively.
- There was no janitorial unit within the housekeeping room. Mop buckets were emptied within the sluice room, which posed a risk of cross contamination.
- There was evidence of a leak from the bedpan washer.

Judgment: Substantially compliant

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 26: Risk management

The risk policy contained all of the requirements set out in the regulations. The local risk register was comprehensive and detailed. Risks were kept under review by the person in charge and were reviewed and updated on a regular basis. The risk register identified risks and included the additional control measures in place to minimise the identified risks.

Judgment: Compliant

Regulation 27: Infection control

The provider did not meet 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. The failure to respond to the potential outbreak in line with national guidelines impacted effective infection prevention, and control within the centre, and may have contributed to onwards transmission.

Equipment, sharps, and waste were not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- The provider had introduced a tagging system to identify equipment that had been cleaned. However this system had not been consistently implemented at the time of inspection. For example, several items of shared equipment had not been tagged after cleaning, and tags were not removed before using some items of equipment.
- Tubs of 70% alcohol wipes were inappropriately used throughout the centre for cleaning equipment. Alcohol wipes are only effective when used to disinfect already "clean" non-porous hard surfaces.
- The detergent in one bedpan washer had expired. This may impact the efficacy of decontamination.
- Mops were dipped into the same bucket of water when cleaning bedroom floors, and although the water was changed frequently and mops were changed between rooms, this practice may lead to cross contamination.
- Safety-engineered sharps devices were routinely used for taking blood samples. However, inspectors observed that the safety mechanism had not been engaged after use. This practice increased the risk of needle stick injury.
- The clinical waste bin was inappropriately located within the medicine room, with general waste being disposed of in this bin.
- General waste bins located in the sluice room were not hands-free, increasing the risk of contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had completed the actions from the previous inspection, and this inspection found that there were adequate precautions in place against the risk of fire.

Means of escape, including corridors and final exit doors were kept clear, and records showed that these were checked on a regular basis. Additional fire signage and upgrades to fire doors had been completed by the provider. Staff who spoke with the inspectors reported that they received annual fire safety training, and attended regular fire drills, and practice evacuations. Staff were clear about the evacuation procedures, and what to do if the fire alarm sounded in the centre. Staff training records confirmed that all staff were up to date with fire safety training requirements.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Overall, the standard of care planning was good and described person-centred and evidenced-based interventions to meet the assessed needs of residents. However, further action is required to be fully compliant. For example:

- The excessive number and volume of care plans resulted in duplication of information and reduced clarity regarding residents' overall care needs.
- Wound assessments were not consistently documented in line with the review time frames outlined in residents' care plans. For example, one assessment had not been documented in over three months, while another had not been updated since 2024. Failure to document reviews increases the risk that deterioration may go unnoticed.
- COVID-19 care plans remained active for some residents without evidence of current infection, exposure risk or assessed need.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' nursing care and healthcare needs were met to a good standard. Residents had timely access to general practitioners (GPs) health and social care professionals, specialist medical and nursing services, including community palliative

care specialists as necessary. Records showed effective oversight of residents' conditions, including regular review by GPs.

Judgment: Compliant

Regulation 8: Protection

The inspectors found that the provider had taken all reasonable measures to protect residents from abuse. Staff who were met in the course of the inspection confirmed that they had attended safeguarding training, and were confident that they would be able to use this training to ensure that residents were protected from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

There were arrangements in place for residents to pursue their interests on an individual basis or to participate in group activities in accordance with their interests and capacities. There was a schedule of activities in place, which was available for residents to attend seven days a week. Residents also had good access to a range of media, which included newspapers, television, and radios.

Residents' meetings were held on a regular basis and meeting records confirmed that there was on-going consultation between the staff and residents regarding the quality of the service provided.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Shannon Lodge Nursing Home OSV-0000383

Inspection ID: MON-0049612

Date of inspection: 26/02/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <ul style="list-style-type: none"> • Following identification of oversight in our outbreak management policy, a full review of policies was implemented and includes suspected outbreaks protocols. Systems have been reviewed and updated to ensure early detection and timely escalation, ensuring that notifications to HIQA and CHO are sent within the notification requirements timeframe. • Infection control education now includes simulations conducted for staff to understand their roles in the event of an outbreak, also alongside this a review will be documented and any learning will be put in place, so that our service can evaluate effectiveness and identify areas where improvement can take place. • The antimicrobial stewardship programme has been comprehensively reviewed and ensures more accurate reviews of prescribing practices. The indication, duration and appropriateness of anti- microbial use are now formally analyzed to identify trends and inform quality improvement actions. Results will be included in governance meetings/clinical meetings and discussed with Gps/ pharmacist. KPIS eg a reduction in antibiotic use. Education will continue for staff. • Cleaning procedures for housekeepers has been reviewed and implemented. Documentation updated ensuring that each room has a separate log for its deep cleaning schedule. This will be audited to ensure ongoing compliance and effectiveness. • Going forward all notifications will be submitted within the requires time frames as per regulations. • The statement of purpose has been reviewed and updated in line with Schedule 1 within the given timeframe of no less than a year, However following on from inspection, more frequent reviews have been identified and is now in place to ensure it remains 	

current, accurate and reflective of the service provided	
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Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: Notification of incidents: <ul style="list-style-type: none"> • All notifications will be completed in accordance with HIQA regulations within the required timeframes. The outbreak management policy has been reviewed and updated in compliance with current regulations; Audits are completed monthly and quarterly to ensure compliance and early detection. 	
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Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Notification of incidents: <ul style="list-style-type: none"> • All notifications will be completed in accordance with HIQA regulations within the required timeframes. The outbreak management policy has been reviewed and updated in compliance with current regulations; Audits are completed monthly and quarterly to ensure compliance and early detection. 	
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Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: <ul style="list-style-type: none"> • A review of all equipment and storage needs has been completed. Only necessary moving and handling equipment specific to residents needs currently subsides in the nursing home. A mattress audit has been completed, and any non-essential items have been removed from multiple storage areas. A designated mattress storage area has been identified. 	

- Following review, the ordering system for cleaning supplies is now completed weekly rather than monthly, ensuring compliance with storage place. Cleaning equipment is currently stored in the designated housekeeping room ensuring safe storage in a key coded door.
- Following inspection, a review of furniture in the home was carried out and items that were worn were removed. All furniture is now in good repair and can be cleaned effectively.
- A bucket less mopping system has been implemented. All housekeeping policies and procedures have been updated in compliance with IPC best practice guidelines. The bedpan washer has now been serviced and repaired following inspection. The service plan remains active.

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Regulation 27: Infection control	Not Compliant
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- Outline how you are going to come into compliance with Regulation 27: Infection control:
- Following identification of oversight in our outbreak management policy. A full review of policies was implemented and includes suspected outbreaks protocols. Systems have been reviewed and updated to ensure early detection and timely escalation, ensuring that notifications to HIQA and CHO are sent within the notification requirements.
 - A structured Clinell clean tagging system is implemented to clearly identify items, equipment, and areas that have been cleaned, sanitized, and are safe for use. Policy has been reviewed and updated and all staff are clear on the correct method of tagging and untagging. Daily checks by the Nurse in Charge, alongside IPC audits, and random spot checks by the Person in Charge ensure compliance. Findings will be documented and corrective actions implemented where required.
 - Alcohol wipes have now been replaced with Clinell Wipe single – use disinfectant wipes containing antimicrobial agents used for the cleaning and disinfecting of non-invasive medical devices and environmental surfaces.
 - All housekeeping policies and procedures have been updated in compliance with IPC best practice guidelines. The bed washer has been serviced and repaired following inspection. The service plan remains active. The bedpan washer has now been replaced
 - Bed pan washer was serviced via contract and appropriate detergent replaced. An extra sluice has been purchased and will be installed next month.
 - Sharps policy reviewed in line with infection prevention and control standards and safe sharp disposal procedures, staff educated and competency assessment in sharps safety

introduced. Disposal procedures are displayed prominently where sharps bin assembled. Supervision and monitoring systems in place.

- The Clinical waste bin is removed from the medicine room. All clinical waste is disposed of in the sluice room only.
- General waste bins in the sluice have been replaced with hands free operated ones. Staff educated regarding infection prevention measures and rationale for above. Regular environmental audits and supervision by management ensure policy and best practice is practiced.

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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:

Individual assessment and care plan:

- A full audit and re- evaluation of care plans was completed by the Clinical nurse managers and instances where duplication within the careplans was identified. Subsequently identified careplans were revised to ensure information is clear, person centred and recorded within the appropriate careplan.
- Staff have been educated on care planning and documentation. Supervision and regular careplan audits have been implemented to monitor compliance and ensure documentation is in line with best practice as per Health Act 2007.
- Covid 19 careplans have been marked as completed and inactivated on Epicare. In the event for a need for such careplans, they will be applied resident specific.

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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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	20/04/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the	Not Compliant	Orange	02/03/2026

	Authority are in place and are implemented by staff.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	04/03/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	27/03/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	20/04/2026
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	Substantially Compliant	Yellow	30/03/2026

	the resident concerned and where appropriate that resident's family.			
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