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:	St. Gladys Nursing Home
Name of provider:	Willoway Nursing Home Limited
Address of centre:	53 Lower Kimmage Road, Harold's Cross, Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	09 September 2025
Centre ID:	OSV-0000686
Fieldwork ID:	MON-0047609

About the designated centre

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

St. Glady's Nursing Home is located in a suburb of Dublin and close to local shops, bus routes and social amenities such as parks. It is a period building which has been developed to each side of the original building. It is registered to provide care for up to 47 residents. There are 21 single rooms, and 13 sharing rooms. Some of the bedrooms are en-suite and there are accessible bathrooms and toilets throughout the centre. The centre provides care of the elderly, but can also support residents under retirement age. The service is provided to residents with low, medium, high and maximum dependency. They focus on meeting residents needs in relation to care of the elderly, Alzheimer's, dementia or psychiatric needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	47

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
Tuesday 9 September 2025	09:00hrs to 17:30hrs	Laurena Guinan	Lead
Tuesday 9 September 2025	09:00hrs to 17:30hrs	Mary Veale	Support

What residents told us and what inspectors observed

Residents living in St Glady's Nursing Home told inspectors that staff looking after them were attentive and kind, and that they 'had no complaints'. However, while there was good care provided to the residents, the inspectors found that since the previous inspection the person in charge was no longer working in the centre and there was no appropriate person appointed to the role. This will be discussed later in the report.

This inspection took place over one day, and the inspectors met with staff, residents and visitors throughout the day. The centre was spread over two floors, in a period property that has been extended. Access between floors was via lifts and stairwells. The centre had a mix of double and twin rooms, and many were seen to be personalised with residents' own photographs and cushions. Some of the bedrooms were en-suite, while others shared bathrooms. Inspectors saw items such as linen trolleys and commodes stored in some bathrooms, and a number of bathrooms had damaged and dirty flooring.

Inspectors saw many positive interactions during the day, with staff engaging residents in casual conversation, and it was clear that staff and residents knew each other well. Staff spoken with showed good understanding of safeguarding residents and managing restrictive practices. Residents said they felt well looked after and they were never left waiting for assistance when they requested it. However, a number of bedrooms were found to be missing call bell devices which was an outstanding action from the previous inspection.

During the day, inspectors observed lunch being served. Residents said that the food served was tasty, and they were given a choice at each meal. While the atmosphere during lunch was calm and unhurried, staff were observed wearing aprons and gloves when assisting residents. When asked, staff said these were used for infection control and to prevent uniforms becoming dirty with food spillages. There was one dining room in the centre and this was seen to be clean and bright. Many residents had their meal from bed tables in the day rooms rather than at dining tables, despite additional communal space being provided.

The centre had a number of communal areas and two of these were seen to be well used on the day of inspection. Two bedrooms had been converted to communal rooms since the previous inspection to provide the residents with sufficient communal space. Neither room was in use on the day of inspection, and this was brought to the attention of the registered provider representative. They reported that staff were actively encouraging residents to use these rooms, but as they were a relatively new addition to the centre, it was taking time for residents to get used to them. Although residents were engaging in activities in the remaining two communal rooms, the large number of people in each room meant that it was difficult for smaller or one to one activities to be encouraged. Despite the restricted

space, the activities co-ordinator was seen to be proactive in including residents in that days' activities, and appeared knowledgeable of residents' abilities and preferences. Residents spoken with said they enjoyed the activities offered, with one resident particularly enjoying parties in the garden.

Residents had access to two attractively designed, secure outdoor areas, one of which had a designated smoking area. A broken chair in this area was brought to the attention of maintenance staff who said they would remove it. There was also a visitor's room available for residents to meet with family, but this room was sparsely furnished and had signs of wear and tear, including a cracked pane of glass on a partition wall. The room was not a comfortable or aesthetically pleasing place in which to receive visitors.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended), review the registered provider's compliance plan from the November 2024 inspection, and follow up on information submitted to the Chief Inspector of Social Services. Inspectors were also following up on the conversion of two bedrooms to provide additional communal space, which had been notified to the Chief Inspector.

Willoway Nursing Home Limited is the registered provider for St Glady's Nursing Home. This company is part of the Grace Healthcare (Holdings) Ireland Limited Group. Inspectors on the day found that the management structure in place did not clearly identify lines of authority and accountability. The person in charge had ceased employment on 29th August 2025, and a new person was due to fill the position in October 2025. However, no appropriate person had been appointed as a person in charge in the interim. Additionally, the registered provider had failed to notify the Chief Inspector of Social Services that the centre had no PIC for a period of time, and therefore were in breach of their conditions of registration. This is further discussed under Registration Regulation 6: Changes to information supplied for registration purposes and Regulation 14: Person in charge.

A review of staff rosters also showed a lack of management supervision at weekends. This will be discussed under Regulation 14: Person in charge and Regulation 23: Governance and management. A clinical nurse manager was responsible for the day to day running of the centre, and they worked full-time in the centre. They were supported in the management of the centre by a clinical nurse manager who worked on a part-time basis, and two regional managers who

visit weekly, one of whom was present on the day of inspection. A complement of nurses and health care assistants, activities staff, housekeeping, catering, administration, and maintenance staff completed the staff team.

The inspectors saw a schedule of meetings between staff, management and residents, and a system of audits. However, these audits did not identify some of the issues seen by inspectors on the day, such as missing call bells. Other audits showed recurring issues still evident on the day of inspection, such as a strong smell of urine from a bathroom, inappropriate storage, and the treatment room left unlocked. This will be discussed under Regulation 23: Governance and management. A menu audit had been conducted by an external company in December last year, and recommendations made were seen to be carried out on the day of inspection. A falls prevention committee had been established, and having implemented falls analysis and falls prevention techniques, falls in the centre had reduced since January 2025, with no falls recorded in August.

Inspectors were provided with a list of maintenance issues by the maintenance manager. Five issues logged as high importance between 11th August and 29th August had not been resolved as of the day of inspection. These included items such as a cracked glass pane in the visitor's room and a door guard not working. The registered provider had completed the compliance plan from the inspection in November 2024, although the safeguarding policy which had been updated required further review to include the procedure for instances of confirmed abuse. These issues will be discussed under Regulation 23: Governance and management.

Despite a weakened management structure, there was an adequate number of staff on duty on the day of inspection, and residents said they were always attended to quickly. There was a good suite of training available to staff in areas such as fire safety and safeguarding. The training matrix seen by inspectors showed a high level of compliance, with training due to expire highlighted for the attention of management. However, over the course of the day, inspectors saw staff practices that did not promote a safe or person centred quality of care, such as the wearing of gloves and aprons at meal times, and fire doors propped open. Staff told inspectors that fire doors were propped open as the door stoppers were broken. These will be further discussed under the relevant regulations.

Inspectors reviewed five staff files. Four of these were found to be incomplete on the day of inspection, and the office of the Chief Inspector was furnished with the missing information the day after the inspection. On the morning of the inspection, a handover sheet which contained personal details of residents was left unattended in a hallway. This sheet was observed in the same place for a period of thirty minutes, with no staff in sight. This was brought to the attention of the clinical nurse manager who said they would direct staff to retrieve the handover sheet and keep it on their person. This will be discussed under Regulation 21: Records.

The inspectors reviewed the centre's incident log and saw that while most incidents were handled and reported appropriately, and within the correct time frame, one incident had not been notified to the office of the Chief Inspector until a month after

it had occurred. This is a repeat finding and will be discussed under Regulation 31: Notification of incidents.

Registration Regulation 6: Changes to information supplied for registration purposes

The Chief Inspector was not notified of the intended change in the identity of the person in charge within the appropriate time frame.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge had finished employment on 29th August. While a new person was due to fill the position in October, the registered provider had not ensured that there was an appropriate person in charge in the interim.

Judgment: Not compliant

Regulation 15: Staffing

There was insufficient managerial staff to ensure the safe delivery of care to residents. This was evidenced by a lack of management supervision at weekends.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to appropriate training and there was a high level of compliance. However, the supervision of staff practices required strengthening to ensure that a safe, person centred quality of care is delivered. This was evidenced by:

- Staff wore aprons and gloves when assisting residents at meal times.
- Inappropriate storage.
- Fire doors propped open.
- Staff wearing masks inappropriately.

Judgment: Substantially compliant

Regulation 21: Records

The system for the safe storage of records was not sufficient as evidenced by personal information on residents left in a communal area.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured that there was a clearly defined management structure in place as evidenced by the absence of a person in charge, and lack of management supervision at weekends.

The management systems in place did not ensure that the service provided was safe and effectively monitored. For example:

- Action had not been taken to address non-compliances from previous inspections.
- Cleaning in the centre did not ensure effective infection control and a pleasant environment for residents.
- Audits had not identified the findings from this inspection and did not ensure that where issues were highlighted, that they were addressed in a timely manner.
- Staff practices were observed that did not promote a safe, person-centred standard of care.
- The safeguarding policy had not identified that a review was required to include the procedure to be followed when abuse has been confirmed.

Judgment: Not compliant

Regulation 31: Notification of incidents

A safeguarding investigation was being conducted into an allegation of financial abuse, but this had not been notified to the office of the Chief Inspector.

Judgment: Not compliant

Quality and safety

Residents who were able to express their views told inspectors they were satisfied with the quality of the care they received. The inspectors observed pleasant engagement between staff and residents throughout the inspection. Notwithstanding these positive findings, the inspectors found that care planning, residents' rights, the premises, and medication management did not align fully with the requirements of the regulations.

The inspectors viewed a sample of residents' records and care plans. 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. However, while some care plans were reviewed at intervals no later than four months, some care plans were not consistent and did not contain appropriate information to guide effective care. This is discussed further under Regulation 5: Individual assessment and care planning.

Residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry of old age, physiotherapy, dietitian and speech and language therapy, as required. The centre had access to GP's from local practices. A GP was visiting residents in the centre on the day of inspection. Residents had access to a mobile x-ray service referred by their GP which reduced the need for trips to hospital. Residents had access to local dental and pharmacy services, and the residents who were eligible for national screening programmes were also supported and encouraged to access these.

Improvements were found in the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) since the previous inspection. Residents were trialled with lesser restrictive techniques, and the administration of medications to manage behaviours had been reduced. There was a policy in place to guide staff, and there was evidence that staff had received appropriate training. Residents had access to psychiatry of later life, and for those with known responsive behaviours, nursing staff had used a validated antecedent-behaviour- consequence (ABC) tool to identify triggers.

There was a positive culture in the centre with an emphasis on promoting a restraint-free environment. Where restraint was used, it was done in accordance with national policy published by the Department of Health. The use of bed rails as a restrictive device was kept to a minimum and had steadily reduced over the previous 12 months. Less restrictive alternatives to bed rails were in use, such as low low beds. Risk assessments were completed, a restrictive practice register was maintained, and the use of restrictive practice was reviewed regularly. The entrance door to the centre was locked, with the intention to provide a secure environment, and not to restrict the movement of residents.

Staff had up-to-date training in safeguarding. Staff demonstrated an appropriate awareness of the centre's safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All interactions between staff and residents were observed to be respectful throughout the inspection. Residents reported that they felt safe living in the centre. The provider was acting as a pension agent for three residents living in the centre. Records reviewed found these pensions were paid into a separate resident's client account to ensure residents' finances were safeguarded. The provider held quantities of monies in safe keeping for a number of residents. The provider had a transparent system in place where all lodgements and withdrawals of residents' personal monies were recorded and signed for by two staff. The provider also audited the balances on a regular basis in line with the centre's policy.

Residents had the opportunity to meet together and discuss relevant issues at resident committee meetings in the centre. An activity schedule was available and activities were available from Monday to Sunday. The inspectors observed that residents had sufficient opportunities to participate in activities in accordance with their interests and capacities. Residents had access to an independent advocacy service, and easy access to daily national newspapers, books, televisions, and radio. Mass took place in the centre monthly, which residents said they enjoyed. Notwithstanding the good practices in the centre, the premises, in particular the communal rooms, were having an impact on the residents' rights. This is discussed further under Regulation 9: Residents' rights.

The design and layout of the centre was generally suitable for it's stated purpose and met residents' individual and collective needs. However, there were many areas of the centre that required refurbishment and repair in order provide a safe and suitable environment for residents. There were many examples observed by inspectors where repair, repainting and replacement were required. For example, flooring, walls, skirting boards and doors were scuffed or damaged. This is discussed further under Regulation 17: Premises.

There was a comprehensive centre specific policy in place to guide nurses on the safe management of medications. Controlled drugs balances were checked at each shift change as required by the Misuse of Drugs Regulations 1988, and in line with the centre's policy on medication management. A pharmacist was available to residents to advise them on medications they were receiving. Further improvements were required in the storage of medications and this is discussed further under Regulation 29: Medicines and pharmaceutical services.

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in Schedule 6 of the regulations, for example:

- Aspects of the premises were not sufficiently maintained internally, and some areas of the centre required painting and repair. For example:

- The inspectors observed scuffed doors, and chipped paint on walls and wooden skirting.
- Flooring on some corridors, en-suite bathrooms, and bedrooms were damaged, preventing effective cleaning.

- A number of call bell devices were missing from residents' bed spaces and bedrooms, meaning residents may not be able to call for assistance while in their bedroom when required. This was a repeat finding from previous inspections.
- There was a lack of storage in the centre resulting in the inappropriate storage of manual handling equipment in communal rooms, and linen skips in toilets and shower rooms. This posed a risk of contamination, and the transmission of infection. This was a repeat finding from previous inspections.
- There was a broken chair in the residents' outdoor designated smoking area which posed a risk to residents using it.
- The centre's laundry area required review as items such as a clothing marking machine, a microwave, and a bag containing footwear, biscuits, wipes and incontinence wear were stored on the floor. This posed a high risk of contamination, and a risk of the transmission of infection.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents expressed overall satisfaction with food, snacks and drinks. Residents had access to fresh drinking water. Choice was offered at all mealtimes and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. Residents' dietary needs were met. There was adequate supervision and assistance at mealtimes.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Practices were observed in relation to the storage of medicines which were not in line with best-practice medicines guidance. For example:

- The office was used to store medicines trolleys, and cabinets to store medicines. The door to the office was open on the morning of the inspection, and a cabinet used to store medicines was unlocked.
- A press located in day space three, which was used to store nutritional supplements, was unlocked.

Medicines not stored securely have the potential to be accidentally ingested by a resident or stolen.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Not all care plans had been updated when a residents' care needs changed or to reflect their assessed needs. For example:

- Three residents did not have their care plans updated following a fall.
- Discrepancies were found in the care plans for two residents.
    - A resident's care plan did not clearly reflect their continence needs.
    - A resident's care plan did not clearly reflect their cognitive ability.

Judgment: Substantially compliant

Regulation 6: Health care

There were good standards of evidence based health care provided in this centre. GP's routinely attended the centre and were available to residents. Allied health professionals such as dietitian and physiotherapist also supported the residents on site where possible, and remotely when appropriate. There was evidence of ongoing referral and review by allied health professionals as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The person in charge had ensured that staff had up-to-date knowledge, training and skills to care for residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). The inspectors reviewed a sample of care plans and saw that person-centred care plans, outlining triggers where evident, and appropriate interventions to support residents with responsive behaviour. The use of bed rails was monitored by the management team, and alternatives to bed rails such as low low beds and crash mats were in use where appropriate. There was evidence of risk assessments when bed rails were in use.

Judgment: Compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to protect residents from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

While the registered provider had provided extra communal rooms, these were seen to be unused on the day of inspection, which impacted on the resident's choice of activity.

Due to the centre having one dining room and one lunch sitting, not all residents had equal experiences. Many residents had their lunch at bed tables in the day rooms. This resulted in many residents spending their day in one room.

Judgment: Substantially 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 6: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Gladys Nursing Home OSV-0000686

Inspection ID: MON-0047609

Date of inspection: 09/09/2025

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**
Registration Regulation 6: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: The change in the person in charge was notified to HIQA on 29/08/2025. The PIC was on leave prior to last working date. The Clinical Nurse manager was deputising in the absence of newly appointed person in charge who was going to start on 06/10/2025. So for 5 weeks , the plan in place was for the Clinical Nurse Manager to manage the home with the support of the Regional Operation Manager and CEO. Following inspection, PIC from another nursing home within the group was operating as PIC until the commencement of new PIC. Going forward, the Chief Inspector will be notified of the intended change in the identity of the person in charge within the appropriate time frame.	
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The change in the Person in Charge (PIC) was formally notified to HIQA on 29/08/2025. The outgoing PIC was on leave prior to their final working day. During this transition period, the Clinical Nurse Manager (CNM) was designated to deputise in the absence of the newly appointed PIC, who was scheduled to commence duty on 06/10/2025. For the interim five-week period, governance and oversight of the centre were supported by the Regional Operations Manager and Chief Executive Officer, ensuring continuity of care and compliance with regulatory standards. Following the inspection, a PIC from	

another nursing home within the group was assigned to act as PIC until the newly appointed PIC formally took up the role.
Going forward:
• The Chief Inspector will be notified in writing and within the required timeframe of any intended change in the identity of the Person in Charge.
• A succession and contingency plan will be maintained to ensure that a suitably qualified and experienced person is always available to fulfil the PIC role during any period of absence.
• The governance structure will be reviewed quarterly to ensure robust oversight and regulatory compliance at all times.

Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
• The Roster has been reviewed and roster management system identifies the Senior Nurse on duty each weekend to ensure clear lines of accountability in the absence of the Clinical Nurse Manager (CNM) and Director of Nursing (DON).
• The Director of Nursing and Regional Operations Manager are assigned on-call responsibility over weekends to provide support and guidance and to respond to any emergencies that may arise.
• This arrangement ensures that appropriate clinical leadership and decision-making support are consistently available, thereby maintaining safe and effective governance at all times.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The training matrix has been reviewed by the Director of Nursing regularly to ensure compliance and ensure all staff have mandatory training in place. Rosters have been reviewed to ensure appropriate skill mix on a daily basis to meet the assessed needs of residents at all times.
• With a background as an Infection Prevention and Control (IPC) Link Practitioner, the Person in Charge (PIC) conducts regular spot checks to monitor compliance with IPC protocols. IPC audits are completed through the Internal Audit System, and action plans arising from these audits are reviewed and implemented in a timely and effective manner.
• Daily spot checks are carried out to ensure that staff consistently adhere to IPC

standards and procedures, safeguarding the health, safety, and welfare of residents. Staff are appropriately supervised, and their practices are monitored and audited to verify that training is effectively implemented in day-to-day care delivery. This ensures that all IPC measures are maintained to the highest standard and that continuous improvement is embedded in practice.
• Staff have been advised to wear blue aprons when handling food and when food is served to prevent cross-contamination.
• Fire and safety training is ongoing for the staff members and education given in staff not to obstruct the fire doors and not to keep fire doors propped open. Maintenance team will complete an audit to ensure an inspection of fire doors is completed and issues are rectified. Weekly Fire activation drill in place to ensure all fire doors are operational.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Staff education provided regarding the GDPR and Clinical Nurse Manager and Nurse on duty ensure the Handover sheets are stored in safe place. Staff have been made aware that any documents containing confidential information should be placed in a secure location.
• Regular spot checks in place. Staff receive appropriate and effective supervision, and their practices are systematically secure and audited to verify that training is implemented correctly and achieves the intended outcomes.

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 HIQA findings regarding governance and oversight, the following actions have been detailed in the Quality Improvement Plan (QIP) for St. Gladys Nursing Home to address identified issues and ensure regulatory compliance:
1. Roster has been reviewed and the Person in charge will oversee and ensure that a Clinical Nurse Manager or a senior nurse will be on duty during the weeekends. The CNM or nurse in charge will be clerarly identified with a colour code.
2. A review of maintenance works will be completed, and a Maintenance upgrade plan will be put in place
3. A review of storage will be completed.
4. All call bells have been reviewed to ensure they are in working order.
5. Housekeeping team have been made aware to adhere to a cleaning schedule to

maintain hygiene and a schedule that reduces the risk of harm and promotes the rights, health and wellbeing of each resident. Daily spot will be carried to ensure safe practices and adherence to IPC protocols.
6. A full review of the audits in the Audit Suite has been completed, and actions and progress and areas of improvement will be communicated to the team.
7. The safeguarding policy will be reviewed to reflect the procedure to follow in the event of a confirmed abuse. This will then be circulated to the team and toolbox talks will be held to ensure the team have full knowledge on the management of a confirmed abuse.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
One notification was not submitted to HIQA within the regulatory timeframe Director of Nursing will ensure to notify any suspected and confirmed abuse will be reported in two days' time frame.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To address the identified issues, the following compliance plan will be implemented.
1. All staff in the home have access to the internal application for lodging all the maintenance issues. The Person in charge reviews this on a regular basis to ensure maintenance logs are actioned in a timely manner. Following the inspection, a meeting was organised with senior management team and Head of facilities and quality improvement plan is in place for the refurbishment of the premises and floor upgrades.
2. Director of Nursing and clinical management team has completed an audit on call bells and the faulty call bells have all been replaced. All staff have been educated regarding residents' rights and restrictive practice and the importance of having access to call bells at all times. to have access to the call to meet their needs.
3. A review of the storage has been completed and a plan in place to store the hoist and wheelchair. Additionally daily cleaning schedule in place for cleaning the equipment and staff education in place to ensure all equipment is clean and disinfected after each use.
4. The broken chair in the garden was removed on the day of inspection.
5. Immediate action taken for the removal of the inappropriate items from the laundry room. Regular walk around conducted by the Director of Nursing Clinical manager to ensure safe practices in place.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
1. The medicine trolleys are kept in the clinical room in Wing B and nurses are reminded to always locked the medication room when unattended.
2. The press located in Day space 3 ensure to kept always locked.
3. The Staff Nurse on duty only have access to the press and Clinical management team ensure to spot check the clinical room and the press for the safe practice in place.

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:
To address the identified issues, the following compliance plan will be implemented

1. A key worker allocation has been updated for all residents to ensure all assessments and care plans are completed. Additionally, the CNM reviews the care plans on a weekly basis to ensure all care plans reflect the care needs of the residents.
2. Following the inspection, a full audit of all residents care plans in underway and will ensure all assessments are updated with current care needs of the residents. The incontinence assessment of each resident has been reviewed and updated.
3. Clinical management team conducts the monthly care plan and an action will be in place for any noted gaps. Quarterly care plan and assessment review is in place to ensure timely updates.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Staff always check with residents and ensure their preferences and wishes are facilitated with regards to their mealtime seating arrangements. Additionally, few residents prefer to have their meals in their own room. A food survey is conducted, and dining experience is discussed ta resident council meetings and all feedback is taken into

account to improve their dining experience.
2. The communal space when not occupied will be set for residents for their meals and have a dignified and enjoyable dining experience.

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
Registration Regulation 6 (1) (a)	The registered provider shall as soon as practicable give notice in writing to the chief inspector of any intended change in the identity of the person in charge of a designated centre for older people.	Not Compliant	Orange	09/09/2025
Regulation 14(1)(a)	The registered provider shall ensure that the designated centre has a person in charge.	Not Compliant	Orange	09/09/2025
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Orange	09/09/2025

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	06/10/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/11/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	10/09/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	10/09/2025
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Not Compliant	Orange	09/10/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Orange	10/10/2025

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	06/10/2025
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.	Substantially Compliant	Yellow	10/09/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs,	Not Compliant	Yellow	10/09/2025

	the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
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	06/10/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/10/2025