



**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:	Millbrook Manor Nursing Home
Name of provider:	Coolmine Healthcare Limited
Address of centre:	Slade Road, Coolmines, Saggart, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	10 February 2026
Centre ID:	OSV-0000763
Fieldwork ID:	MON-0045740

About the designated centre

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

Millbrook Manor was purpose built in 2015 and is provided over two floors. It is in a suburban village in South Dublin. They provide 24 hour nursing care to male and female residents over the age of 18 with low, medium, and high dependency needs. They provide both short and long term care. There are places for 85 residents, with 61 single en-suite bedrooms and two double rooms with en-suite. The centre has a range of communal areas inside, and enclosed garden, and also accessible grounds around the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	78
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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
Tuesday 10 February 2026	06:50hrs to 16:00hrs	Bernadette McDonald	Lead
Tuesday 10 February 2026	06:50hrs to 16:00hrs	Sheila McKeivitt	Support

What residents told us and what inspectors observed

Residents living in Millbrook Manor Nursing Home gave mixed feedback about the service they received. They said that they felt safe and valued the care they received from staff, who they said worked hard to meet their needs. However residents rights were not upheld.

Inspectors arrived at the centre before 7am, met staff, residents and observed practices. Inspectors met two nurses on the ground floor, one of whom confirmed they were the nurse in charge on night duty. Neither of the nurses were able to inform the inspectors of the how many residents were in the centre.

Inspectors observed that a high number of residents asleep in bed did not have access to their call bell, the call bells in these rooms were hanging on the wall out of their reach. Two residents on the ground floor requested inspectors to pass them their call bell, one of whom voiced their frustration at constantly requesting the staff to "leave the bell beside them" and "stating there was no point on having it up on the wall where they could not reach it". Inspectors spoke to the care manager and requested that they took immediate action to ensure every resident had access to their call bell, when inspectors got to the first floor all residents in their bedroom had access to their call bell.

Inspectors observed that there were adequate numbers of staff on day and night duty to meet the needs of residents. In addition, a number of residents spoken with told inspectors that there were enough staff on duty to meet their needs in a timely manner. One resident said that some staff especially the newer ones were "a bit slower at the job" but do get there. The same resident said that a few staff who had been working in the centre for over three years had left and new staff had joined.

The inspectors saw that there were two designated smoking areas in the centre, one was an internal smoking room and the other was a bench at the front of the centre which was used during warmer weather. The smoking room was seen to be set up with appropriate fire safety measures, however, on the morning of inspection there was an overflowing ashtray of cigarette butts on a wooden table in the area, which could create a fire risk.

Bedrooms viewed by the inspector were spacious and nicely decorated with personal belongings such as photographs, flowers, plants and soft furnishings. Residents' reported to be happy with their bedroom accommodation.

Inspectors observed that planned daily activities were displayed on information boards on each floor. The schedule included exercise classes and live music three times each week. While walking around the centre and chatting to residents in communal areas, inspectors observed activities taking place, including residents making valentine cards and playing bingo. Residents were given the choice to

participate and residents said they enjoyed the bingo, exercise class and loved the live music. Although the centre had a well appointed enclosed courtyard, access for residents was restricted. Residents could not access the area independently as the doors were difficult to open and attached to an alarm.

Some residents spoke with inspectors about the quality of the food they received and highlighted that it was good and they received a choice. Inspectors saw that the choice displayed was offered on the day. Inspectors observed the dining experience at lunchtime, the food was well presented and residents received their choice of meal, staff were available in each of the dining rooms to assist residents who required assistance. However, the dining environment required review, the dining room on the ground floor was very busy with residents, so much so that a number of residents did not have access to a dining table. On the first floor some residents were served their meals in the sitting room therefore they did not get the opportunity to enjoy the dining room experience.

Inspectors spoke with a number of visitors who reported that they were very happy with the care their family member received and that the staff were very friendly and caring. Visitors also reported that if they had a concern they could easily speak to staff and the issue would be addressed promptly.

The following sections of this report detail the findings with regard to the capacity and capability of the provider, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

Overall action had been taken to address the majority of the findings of the previous inspection. However, further actions were required by the provider to ensure they come into compliance with the following non-compliant regulations identified on this inspection, regulation 5: Individual assessment & care plan, regulation 9: Residents' rights, regulation 23: Governance and management and regulation 25: Temporary absence or discharge of residents. This will be outlined under the relevant regulations within this report.

This unannounced risk inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 to 2025 (as amended) and to follow up on the compliance plan from the last inspection in February 2025.

The registered provider of Millbrook Manor Nursing Home is Coolmine Healthcare Limited. There was an established management team with clear roles and responsibilities identified. The management team consisted of the registered provider representative and the Person in charge who were both present during this inspection. The person in charge was supported by three clinical nurse managers,

staff nurses, a house manager, health care assistants, activity staff, catering staff, household and administrative staff.

Despite this management structure there was poor oversight of practices in the centre, which impacted on the quality of care being delivered. Established systems were not being implemented in practice. For example, audit schedules were not being followed through and therefore the registered provider did not have clear oversight of the care being delivered. A review of a number of clinical audits identified areas for improvements but action plans, time frames and analysis were not completed in many cases. Many of the audits reviewed by inspectors were of a quantitative nature and did not have a defined action plan, analysis or time bound actions. For example, a wound care audit finding identified the need for staff to follow dressing regimes as instructed by the tissue viability nurse for residents they had reviewed and for staff to attend upcoming wound training. There was no evidence of the follow through or completion of such recommendations. No quality improvements were being brought forward to improve practices in the centre. This is discussed under regulation 23: Governance and management.

Whilst some good practices were observed, for example documentation in relation to the directory of residents and complaints were in line with requirements, other practices such as documentation in relation to contracts of care for the provision of services required improvement. While the gaps in documentation did not present an immediate risk to the users of service, it did affect compliance with regulation 21: Records.

A training matrix was available for inspectors to review, which detailed what training staff had completed. Areas such as fire and manual handling training had identified a date for staff who required refresher training. However, there were large numbers of staff pending refresher in safeguarding training. Training had not been completed in Managing Behaviour that is Challenging.

Regulation 16: Training and staff development

The supervision of staff was not adequate. For example:

- Staff were unable to inform inspectors of the correct number of residents in the centre on the day of inspection.
- Findings under regulation 9, residents' rights were not being upheld.

A review of the staff training matrix and planning identified that the system in place was not robust:

- The training matrix given to inspectors to review showed that a large cohort of staff had not completed refresher training in safeguarding vulnerable residents in the required time-frame.
- Although a plan was in place for mandatory training for staff, appropriate training to meet the needs of the residents was not in place. For example, 47

residents lived in the centre with a diagnoses of dementia, however no staff had completed training in managing behaviour that is challenging.

- Training to support a rights-based approach to care had not completed by any member of staff. Access to this training could positively impact a rights based approach to care, as evidenced under regulation 9: Residents rights.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residence contained all information as requires under schedule three of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to ensure the service provided was, appropriate and consistently monitored were ineffective in a number of areas and improved oversight in aspects of service are required. For example :

- A large number of residents did not have call bell access on the morning of the inspection.
- All Staff did not have appropriate training in place to ensure they could provide care using a rights based approach and meet the safe-guarding needs of the residents.
- Residents rights were not being upheld as evidenced under regulation 9. Residents were not receiving a high standard of nursing care due to a lack of oversight. The standard of nursing documentation was below an acceptable standard as evidenced under regulation 5: Individual assessment and care plan and regulation 25: Temporary absence or discharge of residents.
- Audits completed did not have defined action plans, analysis or time bound actions.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts of care for the provision of service were reviewed by inspectors. The service to be provided and individual fees payable by the residents

for provision of care were clearly specified in the contracts. They also set out the terms and conditions of the residents residency in the centre, including the type of bedroom, but did not identify the room number in three of the contracts.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A sample of three complaints were reviewed and complaints were found to be managed in line with the centre own policy and the requirements of the regulations.

Complainants were provided with a written response to their complaints within the required time frames and the residents spoken with on the day of inspection understood what to do if they wished to make a complaint.

Judgment: Compliant

Quality and safety

It was evident that the team of staff in Millbrook Manor nursing home knew the residents well and worked hard to ensure that the basic needs of residents' were met. However, the over all standard of nursing care being delivered required improvement to ensure residents received a high standard of evidenced-based nursing care.

The inspectors reviewed a sample of residents' records and saw that residents were assessed using a variety of validated tools, however the information within these assessments was not always accurate. The person in charge is required to ensure that care plans reflect current treatment and interventions. For example some care plans in place were updated within four months, however other care plans did not consistently reflect residents' current condition and were not detailed enough to guide practice. This is outlined further under Regulation 5: Individual assessment and care plan.

Residents had access to appropriate medical and social care professionals. Referrals were made to professionals such as General Practitioners (GPs), palliative care, psychiatry, speech and language (SALT), dietitians, and tissue viability nursing (TVN). However, the recommendations made were not always followed through as further discussed under Regulation 6: healthcare.

Inspectors reviewed the transfer documents of a sample of residents transferred out to an acute service in 2026 and found that a copy of the completed transfer letter

was not kept in the centre nor were a copy of the documents sent with resident when transferred, as referenced under Regulation 25: Temporary absence or discharge of residents.

The premises were designed and laid out to meet the needs of residents. However, some improvements were required with respect to the premises. Inspectors observed equipment stored in a number of en-suites making them inaccessible to the resident, a visitors room contained a clinical dressing trolley and two bedroom ceilings had visible water stains. This is outlined further under regulation 17: Premises.

Residents had access to local and national newspapers, television and radio, along with access to an independent advocacy service. There was a programme of activity scheduled daily and inspectors observed residents who were active and socially engaged throughout the day of the inspection. However, inspectors observed some institutionalised practices where residents' rights were not supported, such as no call bell access, as discussed under Regulation 9: Residents' Rights.

There were some measures in place to safe-guard residents from forms of abuse. Notwithstanding this a large cohort of staff had refresher training over due in safeguarding training. The recruitment procedures were robust and all staff had garda-vetting in place prior to commencement of employment. The centre did not act as a pension agent for any resident and safe-guarding a small number of residents' petty cash at their request.

Regulation 12: Personal possessions

Residents had an adequate amount of storage space in their bedroom for personal possessions including a lockable space to store their personal possessions safely.

Judgment: Compliant

Regulation 17: Premises

Notwithstanding the fact that residents were happy with the premises the following issues were identified by inspectors:

- there was equipment stored in a number of en-suites making them inaccessible to the resident.
- the visitors room contained a clinical dressing trolley with clinical equipment, which limited space for visitors and did not provide a homely inviting environment.
- two bedroom ceiling had water stains due to a previously repaired water leak.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

There was no evidence available to show that all relevant information was sent with residents who had recently transferred out of the centre to an acute hospital. Although, the national transfer letter was available on the computerised system it was incomplete for the sample of residents reviewed and there were no copies of documents sent with the resident available for review in their file.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire precautions against the risk of fire were impacted due to fire doors being held open, reducing their effectiveness if there was a fire:

- Two waste bins were observed holding residents bedroom doors open and when questioned staff did not recognise the implication of this.
- Kitchen utensils were placed under kitchenette double doors to hold it open on the first floor.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Gaps were identified in nursing assessments and care plans of those residents with pressure ulcers, from the sample reviewed inspectors observed the following:

- Two of the four residents whose documents were reviewed had incorrect information contained in their latest skin integrity risk assessment. This meant they were identified as at low risk of developing a pressure ulcer when in fact they were living with a pressure ulcer.
- The sample of wound care plans reviewed did not reflect the care the resident required. For example, they did not state how frequently the resident was to be repositioned when in bed or in their chair and the type and setting of the pressure relieving mattress was not included in their plan of care. Three of these mattresses had flashing red lights, which staff did not address until brought to their attention by inspectors.
- A review of night time care documents showed that residents were repositioned on average every four hours, when the centre's policy stated

that repositioning for those residents with pressure ulcers of higher grading was to be completed every two hours.

- One resident with a high graded pressure ulcer did not have a pressure relieving mattress, therefore care was not being provided in line with the centre's policy on pressure area care and their assessed needs.

Judgment: Not compliant

Regulation 6: Health care

Notwithstanding the fact that members of the multi-disciplinary team were accessible to residents, inspectors were not assured that their recommendations were implemented in practice. For example:

- One resident with a pressure wound who had been reviewed by the tissue viability nurse and prescribed a specific dressing regimen did not avail of that treatment as staff had not redressed the wound as frequently as prescribed.
- There was a lack of assurance that residents received care in line with tissue viability nurses recommendations and treatment, as the recommendations made by the tissue viability nurse for each of the four residents reviewed were not reflected in their wound care plan.
- One resident who had been assessed by the tissue viability nurse as requiring a strict repositioning regime, were being re-positioned at ad-hoc times during the day and night.

Judgment: Substantially compliant

Regulation 8: Protection

Notwithstanding the fact that resident's petty cash was stored in a safe and secure place, the process for recording the amount of money being held on behalf of each resident could be improved to eliminate the risk of potential errors, increase residents privacy and increase the security of their monies. Inspectors observed residents' monies stored in envelopes with their name and amount of money written on the envelope.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While residents had their social and religious needs met, a rights based approach to care was not being delivered by staff as reflected from the following findings:

- Multiple residents had no access to their call bell at 7am.
- The two twin bedrooms did not have privacy screening around the bed by the door, hence the residents privacy could not be maintained.
- Staff were observed placing clothes protectors on residents during mealtimes without engaging with the residents or asking consent.
- A cabinet containing residents records in an open plan nurses station on the first floor was not locked.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Millbrook Manor Nursing Home OSV-0000763

Inspection ID: MON-0045740

Date of inspection: 10/02/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>All training programmes are categorised as:</p> <ul style="list-style-type: none"> o Mandatory and voluntary o External and HSELand-based training • Training matrix is reviewed weekly. Progress and action plans are discussed during weekly governance meetings with CNMs and the House Manager. • The Person in Charge (PIC) has enrolled the House Manager in an online Train-the-Trainer course with The Open College, which commenced in March 2026. o Course title: Training Delivery and Evaluation (6N3326), QQI Level 6 • Additional Train-the-Trainer courses for the Clinical Nurse Manager, newly appointed an Infection Prevention and Control Nurse, and Senior Healthcare Assistant will be arranged by the PIC by 15/05/2026. • External mandatory training is currently delivered by Joy-Mac Training and includes: <ul style="list-style-type: none"> o Fire Safety o Manual Handling o CPR o Infection Prevention and Control o Dementia Awareness and Behaviour Management – sessions booked for 08/05/2026; 15/05/2026; 20/05/2026; 27/05/2026 • The following external training sessions are currently scheduled/booked: <ul style="list-style-type: none"> o Falls Prevention -planned for June o Restrictive Practice- planned for July o Dementia Awareness and Behaviour Management -planned for May o Infection Prevention and Control -planned for August • These courses will transition to internal delivery once all Train-the-Trainer programmes are completed. • All staff have completed HSELand Safeguarding of Vulnerable Adults training via HSELand. • All staff are scheduled to complete the HSELand Applying a Human Rights-Based 	

Approach training by 15/05/2026

Regulation 23: Governance and management

Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. Strengthening Daily Oversight and Accountability

- A daily walk-around checklist completed by the CNM/PIC now includes:

- o Call bell accessibility
- o Documentation accuracy
- o Rights-based practice
- o Fire door safety
- o Environmental hazards and secure storage of residents' notes.
- o Pressure relieving mattresses check

- A night duty checklist, completed by the staff nurse, includes:

- o Call bell access checks
- o Documentation accuracy
- o Rights-based practice
- o Fire door safety
- o Environmental hazards and secure storage of residents' notes.
- o Pressure relieving mattresses check
- o Any identified issues are escalated at morning handover to the CNM and reported to the PIC

- CNM night spot-check audits will include verification of call bell accessibility and environmental safety.

2. Audit and Quality Improvement Systems

- The audit system has been reviewed and strengthened:

- o All audits now include:

- A defined action plan
- A named responsible person
- Clear timeframes for completion

- Audit findings are reviewed monthly at governance meetings attended by:

- o PIC
- o CNMs
- o House Manager

- The Registered Provider is informed of all required actions and progress.

3. Governance Meetings and Clinical Oversight

- Weekly governance meetings are held with a structured agenda to ensure effective clinical oversight. This includes review of:

- o Resident dependency levels
- o Hospital admissions and discharges (with care plan review)
- o Multidisciplinary team referrals
- o Palliative and end-of-life care (including RIP residents)
- o Nutritional risk and weekly weights
- o Special dietary requirements
- o Dementia and cognitive impairment
- o Responsive behaviours and risks (including elopement)

- o Diabetes management and blood glucose monitoring
- o Catheter care and due dates
- o Stoma care and skin integrity
- o High-risk medications (e.g. digoxin, lithium, warfarin with INR monitoring)
- o Residents under Psychiatry of Later Life services
- o Complaints and family meetings
- o Infection status and antibiotic use
- o Falls and incident review
- o HIQA notifications
- o Referrals to allied health professionals (SALT, dietitian, OT, TVN) with follow-up on care plans
- o Pressure ulcers and skin integrity issues
- o Training compliance
- o Staffing levels
 - CNMs will be responsible for ensuring:
- o Care plans are updated following all reviews, incidents, referrals and changes in residents' condition
- o Recommendations from allied health professionals are implemented and monitored.
- 4. Reporting and Escalation Structures
 - A monthly governance report is submitted to the Registered Provider outlining:
 - o Key risks
 - o Audit outcomes
 - o Compliance status
 - o Required actions
 - Quarterly trend analysis is completed across:
 - o Falls
 - o Wounds
 - o Infection control
 - o Daily and night checks
 - o Complaints and resident feedback
 - A quarterly quality improvement plan is developed based on identified trends.
- 5. Human Rights-Based Approach
 - All staff are scheduled to complete HSELand – Applying a Human Rights-Based Approach training by 15/05/2026.
 - Compliance with rights-based practice is monitored through daily walk-arounds and audits.
 - Daily walk checks ensuring resident rights and dignity are respected.
- 6. Training and Compliance Monitoring
 - Training compliance is actively managed in line with the action plan under Regulation 16.
 - Weekly training matrix review as a part of governance meeting and monthly reviews ensure outstanding training is identified and scheduled.
- 7. Continuous Improvement and Resident-Centred Care
 - Feedback from:
 - o Monthly residents' meetings
 - o Complaints
 - o Family engagement
 - o Feedback from inspection and audits

is incorporated into governance reviews and quality improvement planning.	
Regulation 24: Contract for the provision of services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:</p> <ul style="list-style-type: none"> • Contracts of care where room numbers have been identified and updated to accurately reflect residents' accommodation details. • New resident admission checklist has been revised to ensure that a room number is clearly documented in the contract of care. • A system has been established whereby any change in a resident's room requires (including resident preference or clinical need or safety) will trigger: <ul style="list-style-type: none"> o A review and update of the contract of care to reflect the changes • CNMs/PIC will monitor compliance through regular documentation checks and audits to ensure all contracts of care remain accurate and with compliance with regulations <p>]</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> • All equipment removed from en suites; weekly checks introduced. • Visitors' room restored to a homely, non clinical environment. • Water stained ceilings repaired and repainted. • Weekly environmental walk through checklist implemented. <p>]</p>	
Regulation 25: Temporary absence or discharge of residents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:</p> <ul style="list-style-type: none"> • A new discharge transfer protocol has been implemented • National transfer letter is now printed from Vcare completed, signed and copied with all relevant document and scanned into the Vcare nurse management system • National transfer letter with Kardex and other relevant documents is completed, copied and kept in the president's personal file • Check list on the transfer letter will be completed and review by CNM as a part of the audits. • All resident transferred to the hospital will have a copy of transfer letter securely stored in V Care system <p>]</p>	

Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> • Magnetic release device (Doorguard) are installed at the door in the resident room if they wish to keep them open at any angle. • The Doorguard Fire Door Retainers keep fire doors open, and in the case of a fire, the Doorguard unit picks up the acoustic signal of an existing smoke alarm and releases the door retainer. The door closes automatically in case of fire alarm. • Fire door checked by staff as a part of check list to ensure fire safety. <p>]</p>	
Regulation 5: Individual assessment and care plan	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <ol style="list-style-type: none"> 1. Care Plan Review and Risk Assessment <ul style="list-style-type: none"> • All residents' care plans have been reviewed and updated to clearly reflect their current risk of developing pressure ulcers. • Risk assessments are now aligned with care plans to ensure consistency between assessed needs and planned care. 2. Person-Centred Repositioning Plans <ul style="list-style-type: none"> • Repositioning schedules are clearly defined within each resident's care plan, including frequency and required supports. • Decline repositioning at night, or difficulty resettling after repositioning, is clearly documented in the care plan, and alternative pressure-relieving strategies where appropriate. 3. Equipment and Pressure Care Management <ul style="list-style-type: none"> • All pressure-relieving air mattresses in use are automatically adjust to the resident's weight to ensure optimal support and comfort. • User manuals for all air mattresses are stored inside residents' wardrobes for easy staff access and reference. 4. Monitoring and Assurance Systems <ul style="list-style-type: none"> • Daily and night walk-around checklists now include: <ul style="list-style-type: none"> o Verification of air mattress functionality o Checks that repositioning is carried out and documented in line with care plans • Any identified issues are escalated to the CNM/PIC and addressed promptly. • All air mattresses have a service contract and rented from Home Care Medical 5. Ongoing Oversight <ul style="list-style-type: none"> • CNMs/PIC will conduct audits of care plans and practices to ensure: <ul style="list-style-type: none"> o Care remains up to date o Interventions are implemented as planned o Documentation accurately reflects care delivered <p>]</p> 	

Regulation 6: Health care	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 6: Health care:</p> <ul style="list-style-type: none"> • Multidisciplinary team (MDT) input is on the weekly governance meeting agenda. o MDT reports and recommendations are reviewed by CNMs to ensure all guidance is incorporated into residents' care plans. o CNMs verify that care plans are updated accordingly and that all recommendations are implemented in practice. • Ongoing MDT involvement and care plan updates are formally reviewed and discussed at each weekly governance meeting to ensure consistent oversight and follow-through. <p>]</p>	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ul style="list-style-type: none"> • New safe for residents' personal finances and valuables was provided • New safe installed in PIC office • New see throughout zip envelopes provided to keep resident's money and valuables • Residents finances book in place with recorded all residents' moneys and valuables • In case of absence of PIC CNM's have access to safe CNM or nurse in charge has an access to residents finances a valuable if requested by resident • Residents personal finance record book is checked monthly and signed by PIC/CNM and House Manager <p>]</p>	
Regulation 9: Residents' rights	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <ul style="list-style-type: none"> • A daily walk-around checklist completed by the CNM/PIC now includes: <ul style="list-style-type: none"> o Call bell accessibility o Documentation accuracy o Rights-based practice o Fire door safety o Environmental hazards • A night duty checklist, completed by the staff nurse, includes: <ul style="list-style-type: none"> o Call bell access checks o Any identified issues are escalated at morning handover to the CNM and reported to the PIC 	

- CNM night spot-check audits will include verification of call bell accessibility and environmental safety.
- Daily reminder talks and updates are communicated by PIC/CNMs on the handover
- All staff are scheduled to complete the HSELand Applying a Human Rights-Based Approach training by 15/05/2026
- Cabinets contained resident records are locked and are checked during the daily check or CNMs/PIC unannounced spot checks – twice a month.
- Lunch and tea time dining on the ground floor was reviewed to allow all residents comfortable dining. There are two sittings at lunch and tea time and residents have a choice to pick preferable one.
- Residents have an opportunity to voice their concerns on monthly meeting.
- Dividing screen to two twin rooms will be provided. It is to maintain resident residents' privacy and dignity.

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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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/08/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/04/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/06/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with	Not Compliant	Orange	30/05/2026

	the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/05/2026
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/03/2026
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that	Not Compliant	Orange	28/02/2026

	all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/04/2026
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).	Not Compliant	Orange	30/05/2026
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 the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/05/2026
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in	Substantially Compliant	Yellow	30/04/2026

	paragraph (1) or other health care service requires additional professional expertise, access to such treatment.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/04/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/06/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	30/06/2026