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:	Joe & Helen O'Toole Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Sean Purcell Road, Tuam, Galway
Type of inspection:	Unannounced
Date of inspection:	01 October 2025
Centre ID:	OSV-0008678
Fieldwork ID:	MON-0043414

About the designated centre

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

Joe & Helen O'Toole Community Nursing Unit is a two storey building containing 48 single en-suite rooms and one twin bedded room. This is a modern building built to cater to the specific requirement of the service users. There is a beautiful enclosed courtyard with rooms around it having undisturbed views. The remaining rooms have views of the sensory dementia friendly garden and adjacent green areas. To the rear of the building there is a large landscaped garden surrounding the building. The centre provides nursing care for older people requiring ongoing care primarily aged over 65 years. Care will also be provided to a number of people under the age of 65 and over the age of 18 years who have been assessed as requiring ongoing care. Continuity of care will be ensured to meet the health and social care needs of dependent adults ranging from low to maximum dependency. 24 hour nursing care will be provided by Registered General Nurses supported by Health Care Assistants. The centre is located in Tuam, County Galway.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 1 October 2025	10:20hrs to 17:20hrs	Fiona Cawley	Lead
Wednesday 1 October 2025	10:20hrs to 17:20hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Inspectors observed that residents living in this centre received care and support which ensured that they were safe, and that they could enjoy a good quality of life. Residents told inspectors that staff were caring and that they made them feel safe living in the centre. Staff were observed to be familiar with the needs of residents, and to deliver care and support in a respectful and calm manner.

This unannounced inspection was carried out over one day. There were 40 residents accommodated in the centre on the day of the inspection and five vacancies.

Inspectors met with the person in charge on arrival to the centre. Following an opening meeting, inspectors completed a walk around the centre observing the care provided to residents, talking with residents and staff, and reviewing the living environment.

Joe and Helen O'Toole Community Nursing Unit is a purpose-built facility providing accommodation to 45 residents situated in Tuam, County Galway. The premises is a two-storey building with residents' living and bedroom accommodation areas located on both floors which were serviced by an accessible lift. Resident bedroom accommodation consisted of mainly single bedrooms and one twin bedroom, all with ensuite facilities. The size and layout of bedrooms was appropriate for residents' needs and ensured their privacy and dignity. Residents were supported to decorate their bedrooms with personal items, such as ornaments and photographs, to help them feel comfortable and at ease in the home. There were adequate facilities available for residents to store their personal belongings and access to facilities for the safekeeping of residents' valuables.

There was a sufficient choice of suitable communal spaces available for residents to use, which provided bright, spacious areas for rest and recreation. Many areas provided residents with views of the outdoors including the gardens areas and the local town. There was also adequate space available for residents to meet with friends and relatives in private should they wish to. Corridors were wide, with appropriately placed handrails, and were maintained clear of items to allow residents with walking aids to mobilise safely around the centre. Throughout the centre, the aesthetics and interior design were of a high standard, creating a welcoming, home-like environment. The centre was very clean, tidy and well-maintained. Call-bells were available in all areas and were answered in a timely manner.

There was safe, unrestricted access to outdoor areas which provided residents with direct access to nature and fresh air. The enclosed gardens contained colourful, seasonal flowers beds and lawns and a variety of appropriate outdoor furniture and shelter.

The registered provider had submitted an application to register the use of the outdoor areas available to residents on the first floor of the centre. These areas

were reviewed on the day of the inspection. Inspectors observed that works to raise the barriers on the terraces and balconies had been completed.

As inspectors walked through the centre, residents were observed relaxing in the various areas. The majority of residents were up and about while others were have their care needs attended to by staff. Some residents were sitting in communal areas, chatting with each other and staff, while other residents mobilised freely or with assistance around the building. A small number of residents chose to spend time relaxing in the comfort of their bedrooms. It was evident that residents' choices and preferences in their daily routines were respected. Familiar, respectful conversations were overheard between residents and staff, and there was a relaxed, convivial atmosphere in the centre. While staff were seen to be busy attending to residents throughout the day, the inspector observed that care practices were unhurried and respectful. Personal care was attended to in line with residents' wishes and preferences. Staff supervised communal areas appropriately and those residents who chose to remain in their bedrooms were supported by staff. It was evident from talking with staff that they knew the residents and their individual needs.

Residents spoke positively about their experience of living in the centre. Residents commented that they were very satisfied with the care they received and their living environment. One resident told inspectors 'the staff are fantastic, every one of them', while another resident said 'all is very good here'. Residents said that they felt safe and secure, and that they could speak with staff if they were worried about anything. There were a number of residents who were unable to speak with inspectors and were therefore not able to give their views of the centre. However, these residents were observed to be content and relaxed in their surroundings.

Inspectors observed visitors being welcomed to the centre throughout the day of the inspection. Inspectors spoke with two relatives who were very complimentary in their feedback and expressed satisfaction about the standard of care provided

The centre provided residents with access to adequate quantities of food and drink. Residents had a choice of meals from a menu that was updated daily. Snacks and refreshments were available throughout the day. Many residents attended the dining room for their lunch, while some residents chose to have lunch in their bedrooms. There were adequate numbers of staff available to residents that required assistance and they were supported with their meal in a respectful and dignified manner.

In summary, inspectors found residents received a good service from a responsive team of staff delivering safe and appropriate person-centred care and support to residents.

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 impacted on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection, carried out by inspectors of social services, to monitor compliance with the Health Act 2007 (Care and welfare of residents in Designated Centres for older people) Regulations 2013 (as amended). The purpose of the inspection was to follow up on the action taken by the provider to address the non-compliances from the last inspection in January 2024. Inspectors found that the provider had addressed the actions required following the last inspection.

This designated centre was first registered in April 2024. On assessment of the application to register, inspectors found a number of issues relating to the premises and fire systems of the centre that would not fully comply with the regulations. The centre was registered with conditions to restrict the occupancy of the centre until fire safety works were completed, and to restrict access to the 1st floor outdoor area until work was completed to ensure the safe use of the outdoor space. At the time of this inspection, five bedrooms remained unregistered.

Prior to this inspection the registered provider had submitted an application to remove these conditions and to increase the occupancy of the centre from 45 to 50.

Overall, inspectors found a good level of compliance across most of the regulations reviewed. Residents told the inspectors that they felt content and safe in the centre, and the standard of care was observed to be delivered to an appropriate standard. However, inspectors found that the provider did not have adequate arrangements in place to ensure all staff had access to appropriate training, in particular fire safety training. This included staff who were rostered to complete night duty on the days following the inspection. As a result, an urgent compliance plan request was issued to the registered provider to address the deficits in fire safety training for all staff working in the centre. The compliance plan submitted following this inspection was accepted by the Chief Inspector.

In addition, the system of oversight in relation to the documentation of individual clinical assessments and care planning was not fully in line with the requirements of the regulations.

The Health Service Executive (HSE) was the registered provider of this centre. There were sufficient resources in place in the centre to ensure that the rights, health and wellbeing of residents were supported. There was a clearly established organisational structure in place, with identified lines of responsibility and accountability at individual, team and organisational level.

The director of nursing, who was the person in charge, demonstrated a clear understanding of their role and responsibility, and they were a visible presence in the centre. They were supported in this role by two clinical nurse managers, and a full complement of staff, including nursing and care staff, housekeeping, catering, administrative and maintenance staff. There were systems in place to ensure

appropriate deputising arrangements, in the absence of the person in charge. Management support was also provided by a general manager for Older Person Residential Services.

The provider had implemented management systems to ensure that there was effective oversight of the quality of care received by residents. Clinical and environmental audits were completed which included reviews of care planning, nutrition, incident management, infection control and safeguarding adults. However, the oversight of nursing documentation was not fully effective. Some care plans reviewed did not clearly describe the intervention required to ensure residents' well-being and safety. Completed audits of the care planning system did not identify these issues and therefore, no corrective action had been taken.

There was evidence of effective communication systems in the centre. The management team met with each other and staff on a regular basis. Minutes of meetings reviewed by the inspectors showed that a range of relevant issues were discussed including clinical issues, training and staff issues.

A review of the staffing rosters found that there were adequate numbers of suitably qualified, competent staff available to support residents' assessed health and social care needs. The team providing direct care to residents consisted of at least two registered nurses on duty at all times, and a team of care assistants. Teamwork was evident throughout the day. Communal areas were appropriately supervised and care practices were observed to be person-centred and respectful. The person in charge provided clinical supervision and support to all staff.

A review of staff training records evidenced that staff had completed relevant training to support the provision of safe care to residents. This included manual handling, safeguarding, managing behaviour that is challenging, and infection prevention and control training. However, a number of staff had not received training in fire safety procedures, and did not demonstrate appropriate knowledge in fire safety management.

There were policies and procedures available to guide and support staff in the safe delivery of care.

The provider had systems in place to ensure that records, set out in the regulations, were available, safe and accessible, and maintained in line with the requirements of the regulations.

There were systems in place to monitor and respond to risks that may impact on the safety and welfare of residents. The centre had a risk register which identified clinical and environmental risks, and the controls required to mitigate those risks. There were systems in place to identify, document and learn from incidents involving residents. Notifiable incidents were submitted to the Chief Inspector in line with regulatory requirements.

The centre had a complaints policy and procedure which clearly outlined the process of raising a complaint or a concern. A complaints log was maintained with a record of complaints received. A review of the complaints log found that complaints were

recorded, acknowledged, investigated and the outcome communicated to the complainant.

Regulation 15: Staffing

The number and skill mix of staff was appropriate with regard to the needs of the residents, and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that a number of staff did not have access to and had not completed up-to-date training in fire safety.

This included new staff, and staff that were rostered to work on night duty together on the days following this inspection.

An urgent compliance plan request was issued to the provider following this inspection, to address this risk. The plan submitted by the provider was accepted by the Chief Inspector.

Judgment: Not compliant

Regulation 21: Records

Records set out in Schedules 2, 3 and 4 were kept in the centre, were stored securely and readily accessible.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to ensure effective oversight of the service were not fully effective. For example:

- inadequate oversight of nursing documentation, particularly in relation to care planning.

- inadequate oversight of training and staff supervision, in particular, fire safety training.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in place which met the requirements of Regulation 34.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider prepared written policies and procedures in accordance with Schedule 5 of the regulations.

Judgment: Compliant

Quality and safety

This inspection found that the management and staff worked to provide a good quality of life for the residents living in the centre. Residents were satisfied with the service they received, and reported feeling safe and content living in the centre. Inspectors observed that residents' rights and choices were upheld.

Each resident had an assessment of their health and social care needs recorded on an electronic documentation system. A care plan was also in place for each resident, detailing the interventions that would be required to meet residents' needs. Overall, care plans reflected the needs of the residents. However, some residents who were assessed as being at clinical risk, for example, nutritional risk, did not have their care plan updated to reflect this assessment. While the direct care of the resident was found to be satisfactory, with the residents' nutritional care needs being met, the lack of up-to-date documentation posed a risk to effective communication between staff and the consistency of care.

The provider had systems in place to ensure residents were provided with access to a doctor, as requested or required. Arrangements were also in place for residents to

access the expertise of health and social care professionals for further expert assessment and treatment, in line with their assessed need.

The inspector observed that residents' rights and choices were respected, and their independence was promoted. Residents were free to exercise choice in their daily lives and routines. Residents could retire to bed and get up when they chose. Opportunities to participate in recreational activities in line with residents' choice and ability were provided. There were sufficient staff available to support residents in their recreation of choice. Residents were supported to attend residents' meetings and to contribute to the organisation of the service. Access to an independent advocacy service was facilitated where required.

The centre promoted a restraint-free environment and there was appropriate oversight and monitoring of the incidence of restrictive practices in the centre. The use of restrictive practices, such as bedrails, were only initiated after an appropriate risk assessment and in consultation with the multidisciplinary team and resident concerned.

The design and layout of the premises was suitable for its stated purpose and met the residents' individual and collective needs. The environment and equipment used by residents were visibly clean and the premises was well-maintained.

Notwithstanding the issue with staff access to fire safety training, the provider had fire safety management systems in place to ensure the safety of residents, visitors and staff. There was adequate emergency lighting, and arrangements were in place for the safe evaluation of residents from the day care area of the centre.

Regulation 11: Visits

Visiting arrangements were flexible, with visitors being welcomed into the centre throughout the day of the inspection. Residents who spoke with the inspector confirmed that they were visited by their families and friends.

Judgment: Compliant

Regulation 17: Premises

The designated centre provided appropriate facilities for the number of residents and their assessed needs, in accordance with the statement of purpose. There was adequate safe and accessible, outdoor space to meet the needs of the residents.

Judgment: Compliant

Regulation 26: Risk management

There was an up-to-date risk management policy and associated risk register that identified risks and control measures in place to manage those risks. The risk management policy contained all of the requirements set out under Regulation 26(1).

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of residents care documentation was reviewed and found to be incomplete. For example, a resident who had been assessed as being at high risk of malnutrition, did not have their care plan updated to address the action required to address the risk.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical and allied health care professionals through a system of referral.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had ensured that residents' rights were respected and that they were supported to exercise choice and control in their daily lives. Residents told inspectors that they felt safe in the centre and that their rights, privacy and expressed wishes were respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Joe & Helen O'Toole Community Nursing Unit OSV-0008678

Inspection ID: MON-0043414

Date of inspection: 01/10/2025

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

All actions identified in the urgent compliance plan relating to fire safety training have now been completed.

To ensure continued adherence to fire-safety requirements:

New staff will be provided in detail orientation of the unit's fire procedures, fire panels and evacuation routes. They will be allocated to attend the earliest possible fire training session since their commencement of employment

All new staff joining the unit will only be rostered for night duty after completing in person fire training.

For agency staff commencing work in the unit, confirmation will be sought from the agency confirming that the staff member has completed fire training.

On commencement in the unit, all agency staff receive full orientation from the CNM2/Nurse in Charge. This includes review of:

- the fire alarm panel
- evacuation routes
- compartmentation layout
- the unit's fire and emergency procedures

This orientation is supported by the induction checklist used for all new/agency staff.

Regulation 23: Governance and management	Substantially Compliant

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

The training matrix was fully reviewed, and all staff with any overdue training were identified.

To ensure ongoing compliance, a CNM2 designated to review and update training matrix on a monthly basis and discuss findings to PIC

Training compliance, documentation audits, incidents, and supervision status included in the unit's governance meeting schedule of items to be discussed to ensure ongoing compliance

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Following the inspection, an immediate and comprehensive review of resident care documentation was undertaken across the unit. This included a detailed examination of all care plans, particularly for residents with identified clinical risks, such as malnutrition.

A meeting with the nursing team was held on 2 December 2025 to review the inspection findings, discuss the outcomes of the care plan review, and agree a revised and standardised approach to care planning. At this meeting, it was agreed that the unit will adopt holistic care plans for all residents.

The required supports for nurses to complete holistic care plans were also identified, including additional training, protected time for documentation, and CNM supervision.

To support implementation:
• In-house training on holistic care planning will commence week beginning 5 January 2026.
• The CNM2's will provide ongoing oversight, coaching and supervision to ensure competency and consistency.
• The service intends to complete the transition of all residents' care plans to the new

holistic format by 30 April 2026.
• Audit and monitoring processes will be done to ensure sustained compliance - monthly CNM audits and quarterly PIC reviews.

The service is committed to ensuring that all residents have a comprehensive, person-centred, evidence-based care plan that accurately reflects their assessed needs and required interventions, fully aligned with regulatory expectations.

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.	Not Compliant	Red	30/11/2025
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	30/11/2025
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	Substantially Compliant	Yellow	30/04/2026

	where appropriate that resident's family.			