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:	Bishopscourt Nursing Home Limited
Name of provider:	Bishopscourt Nursing Home Ltd
Address of centre:	Liskillea, Waterfall, Near Cork, Cork
Type of inspection:	Unannounced
Date of inspection:	10 November 2025
Centre ID:	OSV-0000200
Fieldwork ID:	MON-0044829

About the designated centre

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

Bishopscourt Nursing Home is a purpose-built single storey residential centre with accommodation for 60 residents. The centre is situated in a rural location on the outskirts of Cork city. It is set in large, well maintained grounds with ample parking facilities. Resident' accommodation comprises 36 single and 12 twin-bedded rooms, all of which are en suite with shower, toilet and wash-hand basin. There are numerous communal areas for residents to use including three day rooms, two dining rooms and a visitors'/quiet room with tea and coffee making facilities. There are plenty of outdoor areas including an enclosed garden with seating and raised flower beds. There is also a long corridor called "Flower Walk", in which residents can walk, uninhibited. This is a wide walkway with large glass window panels on either side. Colourful flowers, shrubs and overhanging trees decorated the route. It is a mixed gender facility that provides care predominately to people over the age of 65 but also caters for younger people over the age of 18. It provides care to residents with varying dependency levels ranging from low dependency to maximum dependency needs. It offers care to long-term residents and short term care including respite care, palliative care, convalescent care and dementia care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

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
Monday 10 November 2025	09:20hrs to 17:30hrs	Ella Ferriter	Lead
Monday 10 November 2025	09:20hrs to 17:30hrs	Erica Mulvihill	Support

What residents told us and what inspectors observed

This was a one day unannounced inspection by two inspectors. Throughout the day inspectors met with the majority of the residents living in the centre to gain an insight into their quality of life and the service provided in the centre. Inspectors spoke with 12 residents in detail and overall, residents reported they were happy with the care provided to them. Residents stated that the staff were very kind and gave them time. Over 70% of residents were living with a cognitive impairment and some were unable to articulate their experience of living in the centre. However, these residents appeared comfortable, relaxed and content in their environment and in the company of staff and other residents on the day of this inspection. The inspectors also had the opportunity to speak with seven visitors who said that they were satisfied with the care provided to their loved ones.

On arrival to the centre the inspectors met with the nurse on duty. They were informed that the person in charge was on planned leave and the assistant director of nursing was assigned to manage the centre on the day was on the way to the centre. Inspectors spent time walking around the centre observing care practices and meeting with residents and staff. At the time some residents were in their bedrooms, having finished breakfast and others were being assisted with their personal care. A small number of residents were observed in the main sitting room, which lies in the middle of the centre, enjoying their knitting and chatting with each other. Residents told inspectors they could choose what time they would like to get up in the mornings and staff always respected their choice and preferences. Some residents were seen to be mobilising around the centre independently and were appropriately directed by staff in a kind and compassionate way. Inspectors saw on the morning of this inspection some essential maintenance to bedroom lighting was being carried out. However, residents consent was not always obtained prior to this work commencing in their bedrooms. This is actioned under Regulation 9: Residents Rights.

Bishopscourt Nursing Home is a purpose built single story designated centre for older people, situated in Waterfall, south of Cork City. The centre is registered to provide care to 60 residents and there were 59 residents living in the centre at the time of this inspection. Operationally, the centre is divided into two wings, named Fuchsia and Heather. Bedroom accommodation consists of 36 single bedrooms and 12 twin rooms, all with ensuite facilities. Residents' bedrooms were generally clean and decorated with personal memorabilia, such as photographs, personal items and soft furnishings. Televisions and call bells were provided in all bedroom areas. Throughout the day of the inspection, for residents who chose to remain in their rooms, they were seen to have their call bells responded to in a timely manner. One resident commented that they loved looking out at the greenery and nature outside their window and found it very peaceful. Although the majority of the centre was observed to be clean and well maintained, some areas required attention such as

the laundry and utility room. These and other findings in relation to Infection Prevention and Control are detailed under Regulation 27.

There was a variety of communal spaces for residents to use, including two nicely decorated sitting rooms, the large sitting/day room which was a hive of activity throughout the day and two interconnecting dining rooms. The inspectors observed that the lunch time meal in the dining room was a sociable experience for residents. Tables were seen to be nicely set with tablecloths and condiments and there were a sufficient number of staff available to assist residents. Staff were observed by inspectors offering residents a choice of refreshments during the course of the meal and checking if they would like a second helping of any food. Residents told inspectors that they enjoyed the food in the centre and they could always request alternatives to the menu if they would like.

Residents were consulted on the running of the service through residents meetings that were held regularly in the centre. According to residents, feedback was acted on by the management team and one resident stated "staff are very good to come back to us with updates". Residents who spoke to the inspectors were complimentary about the activity programme in the centre. During the morning, inspectors saw that the activity person was doing both one to one work and art work with residents who wished to take part. Residents were seen to be singing along to music that was playing and appeared content and happy in their surroundings.

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 the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors followed up on the findings of the previous inspection which found that the management systems in place in the centre were not fully effective and did not provide sufficient oversight of the services provided to residents. There had also been an increase in statutory notifications submitted by the registered provider in relation to safeguarding and peer to peer interactions in the centre, and these were reviewed as part of this inspection. Findings of this inspection were that although some improvements were noted in relation to the management of complaints and care planning, significant action was required by the registered provider to ensure that there were effective management systems to ensure a safe service was provided for residents. Action was required to comply with the regulations in relation to governance and management, protection, healthcare, infection control and

residents rights. These findings will be detailed under the relevant regulations in this report.

Bishopscourt Nursing Home is a designed centre for older people operated by Bishopscourt Nursing Home Ltd, who is the registered provider. The company is part of the Grace Healthcare group, who operate ten nursing homes in Ireland. The company consists of two directors, one of whom is the person representing the provider and is directly involved in the operational management of the service. Within the centre the management team comprises of a full time general manager, a person in charge and an assistant director of nursing.

The centre had sufficient resources to ensure effective delivery of care and support to residents. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. There were sufficient numbers of housekeeping, catering and maintenance staff in place. On the day of this inspection two healthcare assistants were on unplanned leave, however, the provider put arrangements in place to replace these members of staff on the day.

There was a training programme in place for staff, and records confirmed that staff were facilitated to attend training in fire safety, manual handling procedures and safeguarding residents from abuse. Staff also had access to additional training to inform their practice, such as infection prevention and control, and training in the management of responsive behaviours. However, a review of the staff training records found that there were some gaps in staff training which is further detailed under Regulation 16. Furthermore, there was not a record of staff having received training in cardiopulmonary resuscitation (CPR) considering some residents living in the centre were documented to be resuscitated in the event of an emergency. An urgent action plan was issued to the registered provider, following the inspection, requiring them to review the healthcare needs of residents living in the centre. The registered provider submitted a response within the requested time line, and provided assurances to the Chief Inspector, that these findings would be addressed. Specifically, the registered provider committed to the provision of training for staff in the days following the inspection and improved oversight of residents' healthcare and staff training requirements.

There were clear lines of accountability at individual, team and service levels, so that all staff working in the service were aware of their role and responsibilities and to whom they were accountable. The provider had management systems in place to monitor and evaluate and improve the quality and safety of the service provided to residents. This included a variety of clinical and environmental audits, weekly monitoring of quality of care indicators. However, these monitoring systems required strengthening. This related to the oversight of staff who were on performance improvement plans, learning from complaints and incidents, the communication processes in place between the management team and the management of safeguarding incidents. These findings are further detailed and actioned under Regulation 23: Governance and Management.

Record management systems consisted of both electronic and a paper based system and documents were well maintained and stored securely. Documents viewed during

the inspection included residents' assessments and care plans, staff training information, residents' admission documentation and the duty rosters. Overall, the records viewed by the inspectors were up to date and well organised. However, a review of the documentation used to inform a residents admission to the centre were found not to be comprehensive, and provided limited information in relation to the residents' history. This is further detailed under Regulation 23: Governance and Management. Records required in relation to staff performance were also not available to review, which is actioned under Regulation 21: Records.

A sample of contracts for the provision of care were reviewed and found that the terms relating to the admission of a resident to the centre, including terms relating to the bedroom to be provided and the number of occupants of that bedroom were clearly described, as required by Regulation 24(b).

Improvements were noted since the previous inspection with regards to the management of complaints. There was an accessible and effective complaints procedure displayed in the main reception of the centre and a review of complaints submitted since the previous inspection found that they were investigated and the complainant was communicated to with regards to whether their complaint was upheld, the reason for that decision and any improvements and recommendations. A record of incidents occurring in the centre was well maintained. All incidents had been reported in writing to the Chief Inspector, as required under the regulations, within the required time period.

Regulation 15: Staffing

The staff compliment and skill mix was adequate to meet the care needs of the 59 residents on the day of inspection. Residents spoke very positively about staff reporting they were kind, caring and respectful. The Person in Charge and the Assistant director of nursing were supernumerary and worked Monday to Friday. The provider rostered a senior nurse at the weekends to work in a supernumerary capacity and to supervise care delivery.

Judgment: Compliant

Regulation 16: Training and staff development

Action was required to ensure that staff have access to appropriate training and supervision as follows:

- The inspectors found that there were gaps in training records particularly around the management of responsive behaviours where sixteen staff members training was out of date. A review of residents files found that a

substantial number of residents in the centre required assistance and support with behavioural and psycho-social issues.
- As mentioned in the first section of this report CPR training was not provided for staff working in the centre. This was contrary to the centres training policy which stated that staff would be trained in this area.
- Two staff members working in the centre, did not have safeguarding training to enable them to detect and protect residents from abuse.

Judgment: Substantially compliant

Regulation 21: Records

Records requested in relation to staff disciplinary actions were not available to view on the day of this inspection. This documentation is required to be maintained and available for inspection as outlined in Schedule 2 of the regulations.

Judgment: Substantially compliant

Regulation 23: Governance and management

Action was required pertaining to the governance and management of the service evidenced by the following findings:

- As found on the previous inspection action was required in relation to ensuring that there was a consistent approach to addressing employee misconduct or performance issues. This inspection found that where performance management plans had been implemented they had not been communicated to relevant managers. This did not provide assurance that these could be effectively implemented and monitored.
- The oversight of the provision of healthcare of the centre was not robust as evidenced under Regulation 6: Healthcare. As mentioned earlier in the report, this required an urgent action to be issued.
- The system in place to assess residents prior to admission was not robust. Specifically, the process in place did not capture key areas of clinical history and therefore clinical risks may not be identified before the resident was admitted. As a result, nursing staff did not have the most up to date information in relation to residents' cognition, behaviour needs and preferences to ensure the service could meet the residents needs.
- Findings of this inspection were the communication processes between management within the centre were weak. This is required to ensure that in the absence of the person in charge the assistant person in charge was provided with all required information to operate the centre.

- The system in place to safeguard residents was not robust, as actioned under Regulation 8.
- Inspectors were not assured that the learning from complaints was shared with the relevant nursing staff and used to improve the quality of the service. This specifically related to learning from complaints pertaining to residents care delivery. Where deficits in care had been acknowledged, there was not evidence of shared learning or new systems put in place to prevent recurrence.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts of care were reviewed which detailed the necessary information including terms relating to the bedroom to be provided to the resident and the number of other occupants of that bedroom if necessary. Details of the services to be provided were also adequately detailed.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of incidents occurring in the centre was well maintained. All incidents had been reported in writing to the Chief Inspector, as required under the regulations, within the required time period.

Judgment: Compliant

Regulation 34: Complaints procedure

A centre-specific complaints policy detailed the procedure in relation to making a complaint and set out the time-line for complaints to be responded to, and the key personnel involved in the management of complaints. The person in charge had ensured that complaints were investigated promptly, complainants were informed of the outcome and it was recorded it they were satisfied with the response to the complaint.

Judgment: Compliant

Regulation 4: Written policies and procedures

The policy relating to staff training and development was not centre-specific and did not clearly specify the required training in relation to CPR for staff working in the centre. Therefore, it did not support the implementation of appropriate training for staff.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that although residents had good access to medical and social care and reported they were content in the centre, resident care was compromised by insufficient monitoring and oversight of the quality and safety of care. Action was required to comply with the regulations healthcare, protection, individual assessment and care planning, infection control and residents rights, to ensure the ongoing quality and safety of the service provided.

Residents had access to a general practitioner (GP) who attended the centre weekly and there was an out of hour's service available at weekends. A review of residents' records found that there was regular communication with residents general practitioners (GP) regarding their health care needs. Improvements were seen in wound care practices within the centre and the monitoring of residents skin integrity. Residents had access to a range of healthcare professionals such as weekly physiotherapy, speech and language therapists, community mental health team and the Integrated Care Programme for Older Persons, a community-based service locally that provides specialist care to older adults with complex needs. However, as mentioned in the first section of this report an urgent action was issued to the provider regarding the provision of healthcare. Where a resident had been transferred to a hospital, inspectors noted the sharing of relevant information about the resident with the receiving hospital to support the safe transfer of care.

Some improvements were found in the assessment and care planning process since the previous inspection. Resident care plans were accessible on a computer based system. A sample of care plans were observed by the inspectors. Care plans generally detailed person centred information and there was good evidence of validated assessment tools being used and updated if there was a change in residents care needs. Notwithstanding these positive findings, further action was required to ensure that pre-assessments of residents for admission to the centre were robust and comprehensive to ensure staff are informed to direct individualised care. These and other findings will be actioned under Regulation 5: Individual assessment and care plan.

There was an effective mechanism in place for the management of restrictive practice that monitored, recorded and reviewed the use of same. Audits were undertaken on the use of restrictive practice by the managers, to monitor trends and areas for improvement. There was evidence that residents who presented with responsive behaviours on the day of this inspection were responded to in a very dignified and person-centred way. Residents living in the centre reported to inspectors that they were content and safeguarding training was provided to staff working in the centre. However, from review of records and discussion with staff and management inspectors found that a number of allegations and incidents of abuse which impacted on the safety and welfare of residents were not being appropriately managed and appropriate action was not taken, in a timely manner, to ensure that residents were protected. These findings are actioned under Regulation 8: Protection.

The inspector found that residents' choices were promoted and respected in the centre. Residents had good opportunities to participate in social activities in line with their interests and capabilities. Residents were supported to continue to practice their religious faiths and had access to newspapers, radios and televisions. Residents were provided with the opportunity to be consulted about, and participate in, the organisation of the designated centre by participating in residents meetings and taking part in resident surveys.

Regulation 25: Temporary absence or discharge of residents

The National Transfer Document was utilised when residents were transferred to acute care. This contained details of health-care associated infections and care requirements of residents to ensure relevant information about the resident was provided to the receiving hospital, where the resident was temporarily absent from a designated centre. Upon residents' return to the centre, the staff obtained information from the acute hospital to inform and direct care**.**

Judgment: Compliant

Regulation 27: Infection control

Further action was required to ensure compliance with the National Standards for infection prevention and control in community services (2018). This was evidenced by the following:

- Some floor surfaces did not appear clean to an appropriate standard such as the flooring in the sluice room and in the laundry area. There were also not records maintained in relation to the cleaning regime in the laundry, therefore, this did not allow for appropriate monitoring and oversight.

- Inspectors observed inappropriate storage of maintenance equipment in the sluice room. This could increases the risk of cross contamination.
- There were a limited number of clinical hand wash sinks available for staff use, which was also a finding of the previous two inspections. Inspectors were informed that these had been purchased and were awaiting instillation on the day of this inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Although some improvements were noted in relation to care planning some further action was required, evidenced by the following findings:

- A resident who was admitted to the centre with a swallow care plan in place from a speech and language therapist, did not have this referenced in their care plan and staff were unaware of these specific recommendations. This posed a risk to the resident.
- Pre-admission assessments were not always completed in full and lacked detail. Therefore, they did not provide accurate information to inform care delivery.
- A resident who had fallen twice in the centre did not have their care plan updated to reflect their increased falls risk.

Judgment: Substantially compliant

Regulation 6: Health care

Action was required to ensure that the registered provider shall having regard to the care plan prepared under Regulation 5 provide appropriate medical and healthcare including a high standard of evidence based nursing care in accordance with professional guidelines for residents. For example:

- Residents care plan documentation indicated they were for resuscitation in the event of a cardiac arrest, training records reviewed indicated that CPR training had not been provided. Discussions with registered nurses working in the centre on the day confirmed that they had not received training in this area. Therefore, the inspectors were not assured that appropriate healthcare could be delivered in the event of an emergency.
- Clinical observations were not always recorded at the recommended frequency, for example when a resident deteriorated. This was a repeat

finding on the previous two inspections of the centre and had not been appropriately addressed by the provider.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

There was evidence of alternatives to bed rails such as low beds and crash mats to reduce the number of bed rails in use in the centre, in accordance with best practice guidelines. The management team were working to reduce the number of bed rails in use in the centre.The GP and physiotherapist were also consulted with regarding the use of restrictive practices such as bedrails. This multi-disciplinary team approach to restraint reduction supported a low incidence of bedrail use in the centre. Where restraint was in use in the centre inspectors saw it was monitored and there were appropriate risk assessments completed. Some refresher training for staff, in the management of responsive behaviors had expired, which has been addressed under Regulation 16; Training and staff development.

Judgment: Compliant

Regulation 8: Protection

The inspectors found that the systems in place to protect residents from abuse in the centre were not robust and did not ensure that all residents were adequately protected. A review of records of safeguarding incidents in the centre found that some incidents had not been appropriately managed. This specifically related to appropriate supervision plans not being put in place, when a safeguarding risks was identified, to safeguard all residents living in the centre. These incidents were therefore not assessed and managed using the centres' safeguarding policy and procedures, to ensure that all residents were appropriately safeguarded in their home.

Judgment: Not compliant

Regulation 9: Residents' rights

Action was required to ensure that residents right to privacy was maintained at all times. Inspectors saw an external contractor, accompanied by a member of the centres staff, was given access to a residents bedroom to do repair work while they

were asleep. The resident had not given permission for this contractor to be in their bedroom.
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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Bishopscourt Nursing Home Limited OSV-0000200

Inspection ID: MON-0044829

Date of inspection: 10/11/2025

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To come into full compliance with Regulation 16, the following actions have been implemented and are underway:
Management of Responsive Behaviours Training
1. Training matrix reviewed; 16 staff identified with expired training and refresher training scheduled for 3rd–4th February; toolbox talks delivered during morning handovers as interim measure with evidence of staff attendance.
2. Ongoing monitoring via Training Matrix with expiry alerts to ensure up-to date training.
CPR Training
1. CPR training arranged for all staff in line with Training Policy that reflects every 2-years CPR refresher as part of mandatory training schedule.
2. Compliance is tracked through the Training Matrix.
Safeguarding Training
1. Two outstanding staff completed safeguarding training on 11/11/2025.
2. Safeguarding training reinforced as mandatory for all staff and is embedded into induction or pre-onboarding for new starters prior to commencing work.
3. Compliance monitored through ongoing audit process.

Monitoring, Governance, and Oversight
1. Monthly training compliance audits conducted by PIC/ADON with HR; and training compliance tracked within monthly KPI reporting under Clinical Governance.
2. HR Administrator responsible for coordination, scheduling, and monitoring.
3. Training Matrix reviewed monthly by General Manager and discussed at management meetings.
4. PIC retains overall accountability for policy oversight and compliance with Regulation 16.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. PIC to ensure all records required under Schedule 21, including staff disciplinary records, are complete, current, and readily accessible to the management team at all times.
2. Review of all staff personnel files to be undertaken to confirm disciplinary documentation is appropriately recorded, stored, and indexed in line with the centre's Records Management Policy.
3. A system has been implemented to ensure all future disciplinary actions are documented contemporaneously and filed correctly within individual staff files.
4. Ongoing compliance to be monitored through management review and periodic records audits.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Consistent Approach to Managing Employee Misconduct and Performance
1. A centralised performance management system is in place to record, monitor, and review all active PIPs, with formal communication to the PIC, ADON, and senior managers.
2. Monthly local management meetings include a standing agenda item to review staff performance and PIP outcomes.
3. Managers have received HR-led training on performance management, documentation, and escalation processes.

Oversight of Healthcare Provision
1. Clinical governance oversight strengthened through daily management walkabouts and clinical spot checks.
2. Regular clinical audits (medicines management, wound care, care planning) are implemented, with findings reviewed at local management meetings.
3. Audit outcomes are supported by clear action plans, assigned accountability, and timelines.
Pre-Admission Assessment Process
1. The pre-admission assessment tool has been revised to ensure it captures comprehensive clinical information, including cognition, behavioural support needs, identified risks, and residents' preferences. Nursing staff will use the comprehensive pre-admission assessment form, which will be stored in the resident's medical file, to ensure

access to up-to-date clinical information prior to admission and to support effective assessment and care planning.
Communication Between Management
1. Weekly governance meetings (Monday and Friday) review incidents, complaints, staffing, safeguarding concerns, and progress on actions.
2. A monthly care meeting with nursing staff and HCAs supports information sharing, learning from incidents and complaints, and identification of training needs.
3. Minutes and action logs are maintained, with progress monitored to ensure accountability and governance continuity.
Safeguarding Systems
1. Safeguarding policies and procedures have been reviewed. All staff have received refresher training in safeguarding vulnerable adults and responding to abuse. Safeguarding incidents are reviewed as part of governance meetings to ensure learning and preventive measures are implemented.
Learning from Complaints
1. A complaints analysis and learning outcomes related to care delivery are now discussed at staff meetings and clinical governance meetings. Where deficits in care are identified, corrective actions and system changes are documented and monitored for effectiveness.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
1. The staff training and development policy has been reviewed and updated to be centre-specific, clearly outlining mandatory training requirements, including CPR, for all nursing staff. The policy assigns responsibility for organizing, tracking, and documenting training, ensures records are maintained and monitored, and establishes regular review processes.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
1. Flooring in the sluice room and laundry areas has been deep cleaned, and a revised cleaning schedule with documented oversight has been implemented.
2. Staff have been reminded of infection prevention and cleaning procedures, and maintenance equipment has been removed from the sluice room and relocated to a

designated storage area to prevent cross-contamination.
3. Ongoing IPC audits and supervision are in place to monitor cleaning standards, storage compliance, and hand hygiene in line with the National Standards.
Following the inspection of May 2025, the provider committed to seeking IPC specialist advice in relation to the provision of additional clinical hand-wash sinks within the centre, with a view to developing a plan of works informed by the CNS advice.
A comprehensive IPC risk assessment was subsequently completed by the CNS in IPC on 31 July 2025, with the final report received on 12 August 2025.
The IPC specialist assessment reviewed the feasibility and safety of installing additional clinical sinks throughout the centre. The assessment identified that installation of sinks within corridor areas would pose safety and fire risks (i.e. evacuation) due to corridor width and layout, and therefore was not recommended.
In line with national IPC guidance and a risk-based approach, the centre has implemented and continues to maintain robust alternative IPC controls, including:
• Alcohol-based hand rub available at point of care
• Enhanced hand hygiene auditing
• Ongoing staff training
• Governance oversight through observation of IPC practices within the home.
The original compliance action related to the commissioning and completion of specialist IPC advice has therefore been completed within the stated timeframe, and the resulting risk assessment has informed current practice.
The scheduling of sink installation is carefully planned to ensure that disruption to resident's routine is minimised (i.e..: dining experience due to dust, hair dressing service, and potential disruption to activities due to noise). A resident forum will be held prior to the commencement of works. Hand wash sink is scheduled to get installed on the 7th of February 2026.

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:
Pre-Admission Assessments
1. Pre-admission assessment form has been reviewed and compared with the assessments used across the wider group. A new, more comprehensive pre-admission assessment tool has been introduced. This assessment captures mental health history and addresses the gaps previously identified.
Incorporation of External Recommendations into Care Plans
1. All residents with existing care plans from external healthcare professionals and the multidisciplinary team will have these recommendations formally referenced and integrated into their individual care plans.
2. The resident's care plan will be reviewed by the PIC and ADON following the nurse's comprehensive assessment to ensure all relevant information, including external recommendations, is accurately transferred.

Updating Care Plans Following Incidents or Changes in Risk
1. Residents who experience falls will be reviewed by their GP, physiotherapist, and have their assessments and care plans updated immediately to reflect increased risk, with appropriate preventative measures documented.
Monitoring and Continuous Improvement
1. Monthly audits of care plans continue to be conducted and will ensure they reflect residents' current needs and risks.
2. Audit findings will inform targeted training for staff and any further improvements required.
3. A clear escalation process continues to be implemented to address gaps in care planning identified during audits.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
1. All registered nurses have up-to-date CPR training, with training records maintained, audited, and refresher training scheduled every 2 years and as required.
2. Staff have completed INEWS and sepsis training (HSELand), supported by 1:1 ADON coaching to ensure timely, accurate clinical observations and escalation in line with INEWS guidance.
3. Clinical oversight strengthened through clear observation protocols, handover checklists, weekend senior nurse reports, and regular clinical governance reviews, with monitoring and escalation to the PIC/ADON.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. Safeguarding policies and procedures reviewed and updated in line with national guidance and best practice, with refresher training provided to all staff on recognising, reporting abuse, and implementing supervision/protection plans.
2. A robust safeguarding recording and monitoring system is in place to ensure all incidents are assessed in line with policy and that supervision plans are implemented immediately where risk is identified.
3. Regular safeguarding audits and multidisciplinary reviews are conducted to identify trends, embed learning, and implement preventative measures, with weekly oversight by the PIC/ADON and escalation to monthly clinical governance meetings.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Staff have been reminded of policies on resident consent and privacy, with ongoing reinforcement through daily handovers and care meetings.
2. A new contractor access protocol requires contractors to be accompanied by staff and verbal consent obtained from residents prior to entering bedrooms, with consent documented in the resident/family communication section of daily notes.
3. Ongoing audits and monitoring are in place to ensure adherence to consent procedures and to safeguard residents' privacy and dignity.

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	04/02/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	13/02/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	24/11/2025
Regulation 27(a)	The registered provider shall ensure that	Substantially Compliant	Yellow	13/02/2026

	infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	24/11/2025
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 where appropriate that resident's family.	Substantially Compliant	Yellow	13/02/2026
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with	Not Compliant	Orange	22/12/2025

	professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	14/11/2025
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.	Substantially Compliant	Yellow	14/11/2025