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:	Carechoice Montenotte
Name of provider:	Carechoice Montenotte Limited
Address of centre:	Middle Glanmire Road, Montenotte, Cork
Type of inspection:	Unannounced
Date of inspection:	28 January 2026
Centre ID:	OSV-0000253
Fieldwork ID:	MON-0049493

About the designated centre

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

Carechoice Montenotte has been in operation as a designated centre since 2003 and is registered to accommodate 111 residents. There are four floors each named after a point in Cork Harbour which can be viewed from the centre - Camden, Carlisle, Currabinney and Roches Point. Each of the floors is a self contained unit provided with day rooms, kitchenette, dining room, staff areas, sluice rooms, assisted bathrooms and storage rooms, a treatment room and a nurse's office. The centre is serviced by stairs and a fully functioning lift between all floors. Resident accommodation is provided in 67 single en-suite bedrooms and 22 twin bedrooms. There is a large Oratory on the ground floor, a sitting room with internet access, a visitors canteen and on the third floor there is an activity room which are all available for residents and relatives use. There is a an outdoor seating area at the front of the centre and a secure garden area which enables residents to walk around an enclosed garden and enjoy safe walkways and seating. The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18. It is a mixed gender facility catering from low dependency to maximum dependency needs. It offers care to long-term residents and to short-term residents requiring transitional, convalescent and respite care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	105

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 28 January 2026	13:00hrs to 21:15hrs	Erica Mulvihill	Lead
Thursday 29 January 2026	09:00hrs to 15:00hrs	Erica Mulvihill	Lead
Wednesday 28 January 2026	13:00hrs to 21:15hrs	Caroline Connelly	Support
Thursday 29 January 2026	09:00hrs to 15:00hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

Overall, the feedback from residents living in Carechoice Montenotte was that they were content living there and that staff were kind and respectful. The inspection took place over two days and on the evening of the first day of the inspection, the inspectors met with many of the 105 residents living in the centre and spoke with over 60 residents in detail throughout the two days to learn about their daily lives in the centre. One resident stated "the staff are very helpful, i feel minded and safe here". Other residents said the activities had improved and they enjoyed getting out when the weather would allow. The inspectors also met with 30 visitors to the centre whom were all very complimentary regarding the care residents received from staff. One relative described how they were facilitated to spend Christmas day with their partner and have Christmas dinner together as they had never been apart since they were married. The relative could not praise the kindness of staff enough.

The inspectors arrived unannounced to the centre at 1pm on the first day of the inspection. The inspectors complied with the centres infection control precautions in place at the front entrance. Upon entering the reception area, the centre was warm, well maintained and a television display of resident activities with music played throughout the day. The inspectors met with the receptionist and the person in charge.

Carechoice Montenotte is a designated centre for older people registered to accommodate 111 residents in a suburb of Cork City. The building is on an elevated site with panoramic views of Cork City and Harbour areas. There were 105 residents living in the centre on the days of the inspection. Bedroom accommodation in the centre is over four floors, and comprises of 67 single rooms and 22 twin rooms. Operationally, the centre is made up of four distinct wings named Camden, Carlisle, Curabinny and Roches Point, each wing named after a point in Cork Harbour.

The inspectors saw that the centre was clean and well maintained. An ongoing programme of works was in place to upgrade areas in the centre. At the time of the inspection, these upgraded areas were observed to be nicely decorated with ample storage for residents to maintain control over their personal belongings. There were a number of communal spaces within the footprint of the centre designated for resident usage. However, on the ground floor and first floor, the inspectors observed that the oratory which was a large communal space was not accessible to residents, and was used as a storage area for Personal Protective Equipment (PPE) and storage of equipment and beds. The upstairs large activities room was observed to be unused also, staff informed the inspectors that due to the change of the activities structure, activities now took place in different venues throughout the centre, therefore this room was rarely used. Up on the top floor, Roches Point, the dining room still remained unchanged from the previous inspection and was observed to have an industrial dishwasher and was not conducive to a homely

environment for residents to enjoy their meals. This will be discussed further under Regulation 17: Premises.

Throughout the evening of the first day of the inspection, most residents were seen to come to the dining rooms for their evening meal. On the first floor second and top floor, dining space for residents was limited, therefore some residents were observed having their meals on a tray in front of them in their armchair due to inadequate number of table settings. This will be discussed further in the report.

The activities programme in the centre over both days was observed to be organised and diverse, with activities taking place in different parts of the centre. Residents on the second floor were observed to be enjoying a session of "laughter Yoga" with an external yoga instructor who came to the centre twice a month. This session was observed to encompass residents, staff and family members who were present and those who took part were seen to enjoy the session. On Roches Point, a bingo session was ongoing and a group of residents who enjoyed this activity had come from different parts of the centre to take part as per their preference.

A small number of residents were seen to be going on an outing with staff accompanying them. They were going to a music session in a local community centre. One resident was dressed up for dancing and spoke to inspectors about how they looked forward to the event weekly.

Residents praised the kitchen staff in the centre for the quality of food served to them throughout the day. A selection of fresh cakes, scones and pastries were observed being offered to residents during the day. A new featured "fine dining experience" was available to residents who wished to avail of this in the ground floor parlour at lunchtimes. On the day of the inspection, the centre had a themed "couples lunch" as a number of residents and their spouses were residents in the centre. Other residents were as per their choice encouraged to partake in this experience also and were supported by staff. The inspector observed the contentment of residents with one resident stating " its very fancy, like being out in the city". Menu choices were available to residents and pictorial menu boards were situated in each dining area.

Inspectors spoke with a number of the aforementioned couples who choose to share a room one of the rooms was set out like an apartment with the couple having been facilitated to have their own three piece suite and other furniture, photographs and memorabilia from home creating a very homely environment. Residents said they were very happy and it was the next best thing to being at home.

Interactions between residents and staff were observed throughout the course of the inspection. Overall, staff were kind, respectful and were very familiar with the care requirements of each resident they cared for. Supervision of communal spaces was evident on the days of the inspection and call bell answering were responded to without delay which was reflected in some residents feedback to inspectors. Notwithstanding this, in some rooms call bells were observed to be missing and required to be replaced so residents had adequate means to communicate if they

required assistance when in their bedrooms. This will be discussed further in the report.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability of the centre and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced inspection was carried out by two inspectors of social services over two days to monitor the centres' compliance with the Health Act 2007 (Care and Welfare of residents in designated centres for older people) Regulations 2013 (as amended). The inspectors also followed up on the actions taken by the provider to address issues identified on the previous inspection of July 2025 where significant non compliance's in Governance and management, supervision of staff, residents rights and medication management had been identified. The inspectors observed early stages of implementation of good management systems which were being embedded in the centre. While improvements were noted in the governance and management systems of the centre, some aspects required further attention to ensure a safe, consistent and quality service was provided to residents living in the centre.These findings in particular, related to staffing, premises and resident rights.

Carechoice Montenotte is a designated centre for older people operated by Carechoice Montenotte Ltd. Nationally, the organisational structure comprises of a board of directors, a chief executive officer (CEO), quality team, finance team, HR and a regional director of operations. This provider was also involved in the operation of 13 other designated centres for older people in Ireland. A clearly defined mangement structure was in place with clear lines of accountability. The centre is managed day to day by by a suitably qualified person in charge, who had support of a general services manager, who also worked full time in the centre and had responsibilities for organisational aspects of the service internally and two Assistant Directors of Nursing (ADONS).

Following the previous inspection the provider took significant action to address the non compliance's identified. A team of senior managers were deployed to the centre to assist the onsite management team, provide training to staff and to implement more robust management and oversight systems. The onsite management team was strengthened by the addition of Clinical Nurse Managers (CNM) to each floor. The ADON's were doing a clinical week to ensure more managerial visibility and supervision on the floor. There was onsite management cover over the weekends

Staffing levels throughout the inspection were observed and a sample of rosters were reviewed.. It was observed on the first evening of the inspection that the night time staffing levels on one floor were not sufficient to meet the requirements of residents as the nurse who had responsibility for these residents, was consistently

being pulled from the staff handover and medication round to assist the care assistant on the floor with residents who required assistance of two staff. This is discussed further under Regulation 15: Staffing.

All staff had access to relevant training specific to their role and responsibilities. A robust training schedule was in place in the centre. Mandatory training in the centre included training in fire safety, dementia care, safeguarding vulnerable adults and infection prevention and control. All new staff underwent a comprehensive induction programme which included mandatory training modules. The registered provider had arrangements in place to ensure adequate and appropriate levels of staff supervision which was supported by the management team to ensure the delivery of health and social care to residents was improved.

Records showed the management team in the centre met with senior management on a regular basis to review and discuss key areas of the service. These records were available to review on inspection. The inspector reviewed a sample of staff files. These contained all of the information and documentation required by Schedule 2 of the regulations, including evidence of An Garda Siochana vetting disclosures and nursing registration with the Nursing and Midwifery Board of Ireland (NMBI).

There was a policy and procedure in place regarding the management of complaints. A review of the complaints log found that complaints were recorded, investigated and managed in line with regulatory requirements.

Regulation 15: Staffing

Action was required by the provider to address staffing levels at night time in parts of the centre:

Whilst there was improvement in staffing rosters in general, night duty staffing levels on the ground floor were not adequate to meet the assessed needs of residents. There was only one nurse and one care staff after 20.00 hours allocated to this floor which has a diverse layout. The inspector saw that the nurse was pulled away from the handover to assist with residents needs and nurses confirmed that were regularly disrupted from medication rounds due to lack of staff to assist residents in the evening time.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider has a robust system of monitoring mandatory training schedules via a comprehensive training matrix. An induction programme for new staff was in place

to ensure that they had the necessary skills required specific to their role. Senior management supervision and support of staff had increased substantially since the last inspection. All training was in date and training plans were in place for those who required updating.

Judgment: Compliant

Regulation 21: Records

The records required to be maintained in each centre under Schedule 2, 3 and 4 of the regulations were made available to inspectors and they were seen to be securely filed and stored. The current roster was reviewed and was seen to reflect the staff numbers present on the day. Staff files were well maintained on an electronic system and the sample seen contained the regulatory documents required.

Judgment: Compliant

Regulation 23: Governance and management

While there had been improvement in the management structure of the centre since the previous inspection with senior management support, The newly implemented governance and management systems were in the early stages and required further strengthening and embedding into the centre to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- There was a lack of oversight of staffing levels at night time on the ground floor as there was not enough staff to meet the assessed needs of the residents. Actioned under Regulation 15: Staffing
- There was a lack of oversight in relation to premises issues. The dining room in Roches Point was not conducive for residents to enjoy a homely environment at mealtimes. This is further outlined under Regulation 17: Premises. This is a repeat finding and has not been actioned from the previous inspection despite an action plan from the provider stating it would be addressed.
- there was a lack of oversight of the dining experience for residents on a number of floors. This is further outlined under Regulation 9: Resident rights. This is a repeat finding from the previous inspection.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts for the provision of care were reviewed. Each contract outlined the terms and conditions of the accommodation and the fees to be paid by the resident or representative for additional services not provided by the GMS system. Their bedroom allocation was also detailed as per regulatory requirements.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all accidents and incidents involving residents in the centre was maintained. Notifications and quarterly reports were submitted as required to meet regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a robust complaints management system. The inspectors found that complaints were promptly managed and responded to, in line with regulatory requirements. Complaints were well recorded, actions were taken and investigation information and follow up documents were available for review.

Judgment: Compliant

Quality and safety

Improvements were seen in the quality and safety of the service for residents since the previous inspection. The inspector found that the residents accommodated in the centre generally experienced a good quality of life. There was timely access to health care services and appropriate social involvement. Staff were known to residents and were knowledgeable of the residents' individual care needs and interactions observed were kind and respectful. There were however, areas of further action required by the provider to enhance the quality and safety to residents in relation to Premises, healthcare, resident rights and managing behaviours that challenge.

The inspectors were assured that residents had good access to their General Practitioner(GP), they attended the centre five days per fortnight. and records demonstrated that referral systems were in place for residents to access allied health and social care professionals, such as dietetics, physiotherapy, speech and language therapy. Independant advocacy services were available to residents if required. Notwithstanding these findings, a review of wound care management documentation did not reflect a high standard of evidence based nursing care; this is further discussed under Regulation 6: Healthcare.

The registered provider had measures in place to safeguard residents from abuse. Staff demonstrated an appropriate awareness of the centres safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse.

Improvements in medication management was seen since the previous inspection. Medication management records were examined and these showed that best practice guidelines were implemented. A review of medication administration had been completed which determined a later morning medication round time afforded residents a better quality of life and allowed staff time to assist residents who required it with their morning meal. Records reviewed showed that all medications dispensed to a resident were given in accordance with the prescriber's instructions for administration.

Residents spoken with were very happy with the quality of food served. There was arrangements in place to monitor residents at risk of malnutrition or dehydration. This included weekly weights where appropriate, maintaining food intake records and timely referral to the dietician and speech and language services. There was improved oversight observed in relation to residents who resided in their rooms for mealtimes. Trays seen coming out of residents rooms where dinners were eaten and those who required assistance were seen to be supported for mealtimes by staff. Notwithstanding these positive findings, the inspectors observed that not all residents had access to appropriate dining facilities and were having their meals served to them on a bed table in the adjoining day room due to lack of space. This will be discussed under Regulation 9: resident rights.

The centre had an electronic resident care planning system. Care planning documentation was available for each resident in the centre, as per regulatory requirements. Care plans reviewed were updated four monthly and some contained detailed information specific to the individual needs of the residents and were sufficiently detailed to direct care.

Staff had up to date training in managing residents with responsive behaviours. Care plans were detailed and person centred with evidence of de-escalation techniques to direct staff to care for residents in a calm and dignified manner. However, the oversight and supervision of restraint usage in the centre required action as the restraint register in the centre did not accurately reflect the amount of restraint practices used which would not provide assurances that restraint was being

assessed and controls were in place to monitor this system effectively. This is discussed under Regulation 7: Managing behaviours that are challenging.

Residents had good access to media, and internet services in the centre. There was a review of the activitiy schedule since the last inspection which the inspectors observed, ensured that different activities were available throughout the day in multiple venues in the centre. On the days of inspection, bingo, laughter yoga, a coffee morning and music and singing were available for residents to attend as per their preference.

Resident views on the quality of the service provided were sought through satisfaction surveys and resident meetings which were held regularly which showed evidence that residents were able to have a say in the running of the centre. Responses from satisfaction surveys showed the majority of residents were satisfied with care received and the centre was conducting an audit of responses from residents as a quality improvement strategy. Notwithstanding this, inspectors observed one resident during the second day of the inspection calling out for a short period of time for staff to assist them. On further review, it was noted that the resident did not have a call bell placed in their room to signal to staff they required assistance. This was a finding in a small sample of rooms checked in the centre and was reported to the management team. This is actioned under Regulation 9: Resident rights.

Regulation 17: Premises

Action was required in some areas of the premises to conform with Schedule 6 of the regulations, some of these are repeat findings that have not been actioned by the provider.

- The dining room on Roches Point was not conducive to a homely environment as there were an industrial dishwasher and sink units as residents walked into the space. This was a repeat finding from the last inspection.
- One bedroom on the top floor, had a breach in the wooden surround of the window which enabled a strong breeze to enter the residents room on the evening of the inspection.
- There was inappropriate storage of beds, furniture and Personal protective equipment (PPE) in the oratory which prevented residents from using this communal space.
- The large activities room in the centre was reported as unused as the activities programme had been transferred to dayrooms throughout. This was a large area of unused communal space that residents did not have access to.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents who spoke with inspectors gave positive feedback on the choice of food available and the quality of food served in the centre. The inspectors saw that residents who required assistance, were provided with it, in a dignified and respectful manner. A review of supervision plans of residents who wished to have their meals in their rooms was completed since the last inspection and the inspectors noted an improved supervision plan for those residents. Some improvements were required to the dining experience in parts of the centre as outlined under Regulation 9: Resident rights.

Judgment: Compliant

Regulation 28: Fire precautions

The inspectors reviewed the fire safety management folder and saw that staff were up to date with Fire Training. Regular simulations of evacuations of the compartments in the centre were undertaken, to ensure staff could evacuate residents safely, in the event of a fire.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Medication administration charts and controlled drugs records were maintained in line with professional guidelines. Medications that required to be crushed for residents with swallowing difficulties were all prescribed individually and ongoing review was observed.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Overall, care plans were person-centred, sufficient to direct care and well maintained by nursing staff. A sample of care plans were reviewed during the inspection and were found to be updated as required, or following a change in the

residents' assessed care. Validated assessment tools were used to inform care planning for each resident.

Judgment: Compliant

Regulation 6: Health care

Action was required to ensure a high standard of evidence based nursing care in accordance:

- On one record reviewed, an assessment was completed which indicated high risk of pressure ulcer occurrence and it was observed on handover documents that staff had reported redness, this was not updated to the residents care plan to highlight to staff requirement of observation for early detection of wounds.
- there were a number of incidents of pressure ulcer development which were managed appropriately but further preventative measures were required to prevent the development of same

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Action was required to comply with this regulation evidenced by the following finding:

Restraint measures were not being monitored effectively in the centre. Inspectors observed nine residents with low low beds and crash mats in place, however, there were only two recorded on the centres' register as restraint. Therefore, inspectors were not assured they were being appropriately assessed for, allocated and monitored.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The following required action to ensure that residents' rights were upheld at all times.

- In the Carlisle floor, the inspectors saw that while the majority of residents were served their meals in the main dining room, six residents were eating

from bed tables in the day room attached, which did not support a sociable dining experience for them. There were similar findings on other floors.

- A number of residents who shared a jack and jill style adjoined bathroom did not have appropriate signage on the doors to ensure that their privacy and dignity could be maintained when occupying same.
- Some residents rooms did not have call bells placed for residents to enable residents to call staff for assistance.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Carechoice Montenotte OSV-0000253

Inspection ID: MON-0049493

Date of inspection: 29/01/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A review of the roster and resident dependency was undertaken following the inspection. As a result, one healthcare assistant shift has been amended to a 09:00–21:00 duty. This ensures that three staff members are present on the unit during the evening period up to 21:00 hours, which is recognised as a busy time for resident care needs. This staffing roster adjustment will support residents with personal care needs during the evening period and reduce interruptions to nursing staff during clinical duties such as medication administration and handover. • Staffing levels and resident dependency will continue to be reviewed by the Person in Charge to ensure staffing arrangements remain appropriate to the layout of the unit and the assessed needs of residents.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • In relation to staffing levels (Regulation 15), the roster for the ground floor unit has been reviewed and amended. One healthcare assistant shift has been adjusted to a 09:00–21:00 duty to ensure increased staffing support during the evening period, providing three staff members on the unit up to 21:00 hours to meet residents' assessed needs and support safe clinical practice.	

• In relation to premises (Regulation 17), the senior management team and facilities department have completed a detailed review of the home. A refurbishment plan is now in place which includes reconfiguration of the dining room on Roaches Point to create a more homely and appropriate dining environment for residents, with the removal of industrial kitchen equipment from the area.

• In relation to residents' rights and dining experiences (Regulation 9), dining arrangements across the centre have been reviewed. Refurbishment plans will support improved communal dining areas to enable residents to enjoy meals in an appropriate dining environment that supports social interaction and dignity at mealtimes.

• In addition to these specific actions, governance and oversight within the centre will continue to be strengthened through ongoing support from the senior management team. The Regional Director of Operations will continue to provide enhanced oversight through regular on-site visits, at a minimum weekly, to support the management team in embedding effective governance systems. The centre will also continue to receive support from the organisation's Governance Team, Facilities and Human Resources departments to assist the management team in strengthening operational systems, monitoring compliance, and ensuring that improvements are sustained.

• Governance oversight will be further supported through regular audits, environmental reviews, and management meetings to ensure that actions identified are implemented and monitored on an ongoing basis. The Person in Charge will ensure that actions arising from the inspection are incorporated into the centre's quality improvement plan and monitored through the governance framework, including regular audits, environmental walkabouts and clinical management meetings.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• The senior management team, in conjunction with the facilities department, have undertaken a detailed review of the premises and a refurbishment plan has been developed to address the environmental matters identified in the report.

• The dining room on Roaches Point is included in the refurbishment plan and will be reconfigured to provide a more homely dining environment. The industrial dishwasher and associated kitchen equipment will be relocated to a more appropriate service area to ensure the dining space is conducive to a comfortable and dignified dining experience for residents.

• The bedroom on the top floor with the damaged wooden window surround has been

reviewed and temporarily repaired. As the building is a protected structure, the works must comply with conservation requirements. The conservation officer and local authority have been consulted, and the provider is awaiting guidance in relation to the appropriate materials and repairs required.

• The inappropriate storage of beds, furniture and PPE within the oratory has been reviewed. This storage arrangement is temporary due to the delivery of new furnishings as part of the wider refurbishment programme. Once these works are completed, the room will revert to its intended use as a communal space for residents and plans are in place to enhance the area to create a comfortable and inviting environment.

• The large activity room within the centre, which was not in active use at the time of inspection, has also been reviewed as part of the refurbishment programme. Plans are in development to repurpose this space as an additional communal area for residents, either as a dining or day space, to ensure residents have access to appropriate communal facilities within the home.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• The Person in Charge has reinforced the requirement that all identified risks, including observations such as skin redness, must be clearly documented and reflected within the resident's care plan to guide staff in monitoring and implementing preventative measures. The care plan that was noted to have a gap on the day of inspection has been updated to reflect the resident's risk of pressure ulcers and current skin integrity status.

• Clinical staff have been reminded of the importance of timely care plan updates and escalation of early indicators of skin breakdown. A review of residents identified as being at risk of pressure ulcer development has been undertaken to ensure appropriate preventative interventions are in place, including repositioning schedules, pressure-relieving equipment and regular skin integrity assessments.

• The clinical management team have strengthened oversight of wound care through regular review of wound documentation, monitoring of incidents relating to pressure ulcer development, and the completion of root cause analysis where wounds occur to identify opportunities for improved prevention.

• A Quality Improvement Plan has been commenced to focus on wound management, aiming to enhance early wound identification, assessment, prevention, and treatment, while ensuring ongoing staff education and monitoring of outcomes.

• Ongoing monitoring will also be supported through the centre's clinical audit programme and governance meetings to ensure continued oversight and improvement in practice.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: • Following the inspection, a full review of all restrictive practices in use within the centre has been completed by the clinical management team. This review included the use of low-low beds and crash mats to ensure that each intervention has been appropriately risk assessed and considered in line with the principles of least restrictive practice. • The centre's restraint register has now been reviewed and updated to accurately reflect all restrictive practices currently in use. Individual resident assessments have been reviewed to ensure that appropriate risk assessments, care plans and monitoring arrangements are in place. • Where restrictive practices are deemed necessary, the rationale for use, alternatives considered, and consent processes are clearly documented in the resident's care plan. • The Person in Charge will ensure ongoing oversight of restrictive practices through regular review of the restraint register, monitoring through the centre's audit programme, and discussion at governance and clinical management meetings to ensure compliance with best practice and regulatory requirements.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • A review of dining arrangements has been undertaken as part of the wider refurbishment programme currently planned for the centre. This refurbishment will include the provision of improved communal dining spaces to ensure that residents have access to an appropriate dining environment that supports a social dining experience at mealtimes. In the interim, staff have been reminded of the importance of supporting

residents to dine in the dining room where possible, in line with their preferences and assessed needs. The clinical management team will monitor adherence to this approach on a daily basis.

• In relation to the Jack and Jill style bathrooms, appropriate signage has now been installed on the adjoining bathroom doors to support residents' privacy and dignity when the facility is in use.

• A review of all resident bedrooms has also been completed to ensure that call bells are available and accessible in each room. Call bells have now been installed or repositioned where required to ensure residents can summon assistance when needed.

• The Person in Charge will maintain oversight of these areas through regular environmental walkabouts, monitoring through the centre's audit programme, and review at governance and management meetings to ensure that residents' rights, privacy and dignity continue to be upheld in practice.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	29/01/2026
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/10/2026
Regulation 17(2)	The registered provider shall, having regard to	Not Compliant	Orange	31/10/2026

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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 the statement of purpose.	Substantially Compliant	Yellow	30/06/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/10/2026
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 professional guidelines issued by An Bord	Substantially Compliant	Yellow	31/05/2026

	Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/05/2026
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.	Substantially Compliant	Yellow	31/10/2026