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:	29 July 2025
Centre ID:	OSV-0000253
Fieldwork ID:	MON-0047818

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:	101

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 29 July 2025	08:30hrs to 18:10hrs	Ella Ferriter	Lead
Tuesday 29 July 2025	08:30hrs to 18:10hrs	Caroline Connelly	Support
Tuesday 29 July 2025	08:30hrs to 18:10hrs	Erica Mulvihill	Support

What residents told us and what inspectors observed

Overall, residents living in Carechoice Montenotte told inspectors they were content living in the centre. Throughout the course of the inspection, inspectors spoke in detail with 25 residents. Several residents spoke highly of the staff and said they were kind and respectful towards them. A few residents said that although staff were very busy they were "extremely nice people" and "they do everything they can to make you happy". One resident stated that although staff are kind and obliging, communication with staff can sometimes be difficult. The majority of feedback provided to inspectors with regards to the quality of care and activities provided was positive. However, one resident told the inspector that they were sometimes woken up early and they would rather stay in bed. From discussions with staff and observations of practices within the centre the inspectors also found that some residents were being woken early, washed and dressed to facilitate staff who were coming on day duty. This was not in line with ensuring residents had choice with regards to how they spent their day.

Inspectors arrived unannounced to the centre and were met by the person in charge and the recently appointed general services manager. During an initial walk around the centre, inspectors observed care provided to residents. There was a calm atmosphere in the centre, as staff were observed assisting residents with their daily requirements. The inspectors observed respectful interactions and a good, personal rapport between staff and residents. Inspectors met with the person in charge for an introductory meeting shortly after the walk around.

Carechoice Montenotte is a designated centre for older people registered to accommodate 111 residents in Cork City. The building is on an elevated site, with views over Cork Harbour. There were 101 residents living in the centre on the day of this inspection. Bedroom accommodation in the centre is over four floors, and comprised 67 single rooms and 22 twin rooms. Operationally, the centre is made up of four distinct wings named Camden, Carlisle, Currabinny and Roches Point, each wing named after a point in Cork Harbour. Inspectors viewed a sample of bedrooms and saw there was sufficient storage facilities for residents' clothing. Many of the bedrooms were personalised with residents' own belongings and family pictures. Bedroom doors were different colours and resembled the front door of a home, which made it clearer which room belonged to each resident. This is particularly important for signposting for residents with cognitive impairment.

There was a spacious patio area to the front of the building with an array of flowers and garden furniture. There was a further garden area, below the car park, for residents to use, which was seen to be very well maintained. Inspectors observed a large marquee, to the right of the centres entrance, where some residents were observed relaxing during the day. Staff were observed encouraging residents on all floors of the centre to go out to these areas and enjoy the sunshine and good July weather.

A plan of refurbishment works within the centre was ongoing, with further upgrades planned throughout the centre. Premises upgrades were evident in the reception area, ground floor and on the 3rd Floor of the centre. Many bedrooms had new flooring, had been repainted and had new wardrobes fitted. The centre was visibly clean on the day of this inspection and household staff were observed to have good cleaning practices, which were consistent across each floor. Notwithstanding these positive changes, inspectors found that a review of the layout and the decor of the dining room on Roches Point was required, to ensure it was reflective of a homely environment as well as a review of the overall temperature regulation system in the centre. These findings are further detailed under Regulation 17.

Visitors were seen coming to the centre throughout the day. Many of them sat outside on the patio area, with their family member and others visited residents in their rooms. Inspectors met with approximately 11 visitors and the majority of them spoke very highly about the care their family member received. They said that the staff were very kind and always worked very hard. However, one visitor stated the supervision when their family member was in the day rooms could be improved, as well as attention to their loved ones personal care.

Residents who attended the dining rooms were seen to have a social dining experience, where they were chatting with staff and other residents. The tables were appropriately set with condiments available. Inspectors acknowledged that the dining experience for residents had improved since the previous inspection with more residents using the dining facilities. However, there continued to be a number of residents having their meals on armchairs in the sitting rooms, with a bed-table in front of them. This did not fully promote a social dining experience and is actioned under Regulation 9. Inspectors observed that the food served looked appetising and was well presented. Visual picture menus were on display on the dining room walls, so that residents could see the choices of meals available to them. For residents who remained in their bedrooms for their meals inspectors observed inadequate supervision of some of these higher dependency residents. For example; some residents were not assisted into an optimal position to enjoy their meal and some plates were seen to be removed from resident's rooms with minimal food eaten during the lunchtime meal. These and other findings are actioned under regulation 18; Food and Nutrition.

There were two people allocated to activities in the centre, both worked 9:00 am to 5:30pm. Inspectors were informed that a recent review of the activities schedule was carried out and had led to enhancements to the programme, including additional hours allocated at the weekend. Activities on the day of this inspection included trips outdoors, quizzes and a food tasting group. However, activities available to residents residing on the top two floors of the centre was limited on the day and the inspectors observed that some of these residents spent a considerable amount of time with minimal stimulating activity on these floors. These findings are further detailed under Regulation 9; Residents Rights.

The following sections of this report present the findings of this inspection in relation to governance and management in the centre, and how these arrangements impact the quality and safety of the service being delivered to residents.

Capacity and capability

This unannounced inspection was carried out by inspectors of social services over one day to monitor the centre's compliance with the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulation 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 2024. Overall, findings of this inspection were that while the governance and management of the centre was satisfactory, some aspects of the management systems were not robust and did not provide adequate assurance that a safe, consistent and quality service was provided to residents living in the centre. These findings particularly related to the supervision of staff, medication management, food and nutrition and residents 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), and a regional director of operations. This provider was also involved in operating 13 other designated centres for older people in Ireland. The staff in the centre benefited from access to and support from centralised departments, such as human resources (HR) who are available on site, a quality department and finance. A clearly defined management structure was in place with clear lines of authority and accountability. The provider had recruited a general service manager, who worked in the centre full time and had responsibilities for operational aspects of the service internally. Although, there were many good management systems in place the inspectors found there had been a recent deterioration in management oversight and staff supervision, to ensure the quality of the service provided to the residents is safe appropriate and effectively monitored. This is detailed under Regulation 23, Governance and Management.

The centre is managed day to day by a suitably qualified person in charge, who had been in post for over six years. The person in charge was supported by two assistant directors of nursing. Staffing levels in the centre were sufficient on the day of inspection for the size and layout of the centre. Inspectors were informed that there had been a turnover of staff since the previous inspection, however, vacant posts had been recruited and filled and there was ongoing recruitment with the assistance of the HR department. The registered provider had staffing levels under constant review and had increased the staffing complement of activities personnel since the previous inspection.

All staff had access to relevant training. Some training courses were mandatory for all staff, for example safeguarding of vulnerable persons and moving and handling. Well-maintained training records were reviewed by inspectors and were found to be

up to date with a training schedule evident for future training sessions. However, the registered provider had inadequate arrangements in place to ensure appropriate levels of staff supervision were in place. This lack of staff supervision, monitoring and support had a direct negative impact on the delivery of health and social care to residents, as detailed under Regulation 16.

A number of areas of good practice and improvement were noted specifically in relation to complaints management and the collection of key performance indicators in falls, restrictive practice and residents' weights. This information was reviewed monthly and trended to identify learning and areas for improvement. Investigation and follow up with complainants was evident in the documentation reviewed, evidencing that the provider was being responsive to residents and relatives.

Communication systems were in place between the registered provider and management within the centre. However, there limited amounts of internal staff meetings to ensure that there were effective communication systems in place and to ensure that all staff were aware of key clinical and operational aspects of the service. Inspectors also followed up on the findings of the previous inspection in relation to fire safety. Notwithstanding the positive actions taken by the provider in relation to installation of new fire doors, the provision of fire training yearly for staff and arranging the local fire department to assess and familiarise themselves with the premises, further actions on fire evacuation drills was required. These findings are actioned under Regulation 23.

Records were seen to be maintained and stored adequately and met legislative requirements. Records reviewed by inspectors, as required by Schedule 2, 3 and 4 of the regulations, included resident care records, staff files and the statement of purpose. An electronic record of all accidents and incidents were recorded and all had been notified to the Chief Inspector, as required by the regulations.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the centre within the required time frame. The prescribed documents, as set out in the regulation had been submitted, such as the floor plans and the statement of purpose. The required registration fees had been paid.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was full-time in post in the designated centre. They had the required experience, skills and qualifications as set out in the regulations. They demonstrated good knowledge of their role and responsibilities.

Judgment: Compliant

Regulation 15: Staffing

Based on a review of a sample of staff rosters and the size and layout of the centre, inspectors found that there was an adequate number and skill-mix of staff, to meet the assessed needs of the residents on the day of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There were inadequate arrangements in place to ensure appropriate levels of staff supervision were in place. This lack of staff supervision, monitoring and support had a negative impact on the delivery of health and social care to residents. For example:

- There was poor supervision of staff who provided meals to residents in their bedrooms. Residents were seen not to be assisted into an optimal position to enable them to eat their meal, by way of example two residents were seen lying flat in their beds and not sat up to facilitate the appropriate consumption of their meal.
- Some residents were woken early by staff to be washed and dressed. This was to facilitate staff working practices and staff routine. This did not respect residents rights and was deemed an inappropriate care practice.
- Some poor medication management practices were observed, where the administration of crushed medications had been delegated to healthcare assistants. This was contrary to nursing professional guidelines and safe medication practices and posed a risk of medication errors occurring.

Judgment: Not compliant

Regulation 21: Records

Records required to be maintained in each centre under Schedule 2, 3 and 4 of the regulations were made available to the inspectors. They were well maintained and stored securely.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had an up-to-date contract of insurance in place, as required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required action to ensure that the service provided was safe, appropriate, and consistent, for example:

- The system in place for the supervision of staff was not sufficiently robust pertaining to food and nutrition, medication management and residents rights, as discussed throughout this report.
- There were limited staff meetings taking place in the centre and there were not effective arrangements in place for staff to raise concerns about about the quality and safety of care and support provided to residents. This did not provide opportunities for management to engage with staff on current concerns within the centre and areas for quality improvement.
- A review of fire evacuation drills of the largest compartment since the previous inspection found that one had been simulated with night time staffing levels. This did not provide assurances that all staff would be competent to carry out full compartment evacuation drills, when staffing is at its lowest.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of Purpose was reviewed and it contained all information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge ensured that all required incidents were notified to the Chief Inspector within the specific time frames, set out by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre had a complaints procedure that outlined the process for making a complaint and the personnel involved in the management of complaints. A review of complaints found that they were recorded, acknowledged, investigated and the outcome communicated to the complainant. Complaints were analysed and key learning objectives were established for staff and management.

Judgment: Compliant

Quality and safety

Although residents spoken with were mostly content in the centre and satisfied with the service provided, the inspectors found that action by the provider was necessary to ensure that resident's rights were upheld and that there was effective oversight of residents care delivery and medication management practices in centre. These findings will be further detailed under the relevant regulations of this report.

Residents were provided with appropriate and timely access to general practitioner services. Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy and occupational therapy, through a system of referral. Wound care practices within the centre were reviewed and were found to be in line with evidenced based nursing care.

The inspectors reviewed a sample of residents' care records. Records showed that nursing staff used validated tools to carry out assessments of residents' needs prior to and on admission to the centre. These assessments included the risk of falls, malnutrition, and assessment of cognition and dependency levels. Care plans reviewed by the inspectors were of a good standard and included sufficient up to

date information in relation to residents' current needs. Therefore, they provided staff with adequate guidance and direction to provide care as needed for residents.

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. Medicines requiring strict controls were appropriately stored and managed. Secure refrigerated storage was provided for medicines that required specific temperature control. However, some medication administration was not in line with safe medication practices, as outlined Regulation 29: Medicines and Pharmaceutical services.

There were arrangements in place to monitor residents at risk of malnutrition or dehydration. This included weekly weights, maintaining a food intake monitoring chart and timely referral to dietetic and speech and language services, to ensure best outcomes for residents. However, the oversight and supervision of resident's nutritional intake, when they chose to remain in their bedrooms required to be enhanced, as detailed under Regulation 18.

There was evidence that residents who presented with responsive behaviours were responded to in a very dignified and person-centred way. The majority of these residents care plans were seen to outline de-escalation techniques, and ways to effectively respond to behaviours. There was evidence of risk assessments and care plans in place for all uses of restraint in the centre. A policy was available to guide staff on management of and use of restrictions in the centre and training was provided in this area. The centre had reduced the number of bedrails in use since the previous inspection and were focusing on moving towards a restraint free environment. However, where restraint was used it was found that associated documentation did not always reflect the resident's most recent assessment and the least restrictive option was not always used. These and other findings are detailed under Regulation 7.

Residents had access to media such as radio, television and wireless Internet access in the centre. A review of documentation evidenced that there was also opportunity for residents to be consulted about, and participate in, the organisation of the designated centre by participating in residents meetings and taking part in resident surveys. Inspectors reviewed records of resident and relative committee meetings which were held every twelve weeks and any agenda items of concern were completed and reported back to residents and relatives at the next available meeting. Residents were encouraged to access their community and external day services where appropriate. There was availability of advocacy services and evidenced that they had been availed of for some residents. However, as mentioned in the first two sections of this report action was required in relation to ensuring resident's rights were upheld in relation to residents choice, which is actioned under Regulation 9.

Regulation 11: Visits

Visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were facilitated to meet with their visitors in their bedrooms or in the communal spaces indoors or outside in the gardens.

Judgment: Compliant

Regulation 17: Premises

Action was required in some areas of the premises to conform with Schedule 6 of the regulations, evidenced by the following findings:

- On the day of the inspection some areas of the centres were very warm, particularly the top two floors of the centre and the dining room in Roche's point. It was evident that there was not a system in place to ensure that the internal temperature is maintained at recommended guidelines, as there were no thermostats available on these floors. Some residents living on these floors may not be able to verbalise if they are too warm or uncomfortable and may also need to support to maintain their body temperature. Therefore, the monitoring of the air temperature required action by the registered provider to improve temperature regulation in this part of the centre.
- The dining room on Roches point was not conducive to a homely environment as there was an industrial dishwasher, and sink units close to the entrance. The management team informed the inspectors that there was a plan to reconfigure this room in the coming months.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Observations of the inspectors evidenced that food was not always provided to residents in line with their assessed dietary needs and appropriately monitored. For example:

- A review of a residents intake records evidenced that these were not maintained accurately. Therefore, it would not be possible to ascertain if sufficient food and fluids had been consumed in the 24 hour period. Inspectors observed some trays of food being removed from residents' rooms, where it appeared only a very small amount of food had been eaten. This was not being appropriately recorded or communicated to senior staff. This did not assure there was appropriate oversight of residents dietary needs.

- As described under Regulation 16 some residents who required assistance at mealtimes did not always receive this assistance in a timely manner**.** For example, inspectors saw that one residents hot meal was left in front of them, when they required assistance to consume it. Therefore, the meal was cold by the time staff were available to assist them.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors were not assured that residents were protected by safe medication management practices and procedures or that the centre's medicines management policy was adhered to. This was evidenced by the following findings:

- Inspectors observed a resident being administered medication by a healthcare assistant on the day of the inspection. Discussions with staff indicated that for residents who required medications to be crushed or administered with their meals this was sometimes delegated to a healthcare assistant. This did not provide assurance that medications were administered as per nursing professional guidelines and the centres policy. This unsafe administration practice posed a risk of medication errors. The management team committed to reviewing this practice, on the day of this inspection.
- One residents prescription chart did not have clear indication with regards to what individual medications were suitable for crushing. This may result in a medication error, if a medication was crushed when it was not compatible for crushing.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents care planning documentation was maintained to a good standard. Care plans were initiated within 48 hours from admission and informed the care provided by staff. Daily progress notes were sufficiently detailed and were being maintained by nursing staff.Each resident had a care plan in place that detailed their needs and preferences for care, support and daily routines. The inspectors found that residents' care plans were person-centred and together with a range of validated assessment tools, they were reviewed on a four monthly basis or more frequently if required.

Judgment: Compliant

Regulation 6: Health care

Residents had good access to their general practitioners (GP) who visited the centre routinely and as requested by nursing staff and residents. Out of hours medical cover was also provided. A variety of other healthcare practitioners were available to support the residents which include a physiotherapist who visited weekly, access to tissue viability nurse, dietetics, speech and language therapy and chiropody. Residents had access to occupational therapy services on referral. Inspectors were assured on the day of this inspection that a resident with complex care requirements was being referred to Occupational Therapy Services for a seating assessment.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Action was required to comply with Regulation 7, evidenced by the following findings:

- Restrictive practices were not always managed in accordance with the centres policy and the national restraint policy guidelines. For example; where a resident required a restrictive practice for their safety or well being, the least restrictive option was not always used. One resident was allocated four different types of restraint, however, their risk assessment indicated they were not at risk of falls from bed. Therefore, there was not always rationale for the use of these restraints.
- One resident who had responsive behaviors did not have sufficient information in their behavioral support plan with regards to de-escalation techniques and ways to effectively respond to their behaviours.
- The inspectors observed that the dining room on Roches Point was kept routinely locked. Therefore, residents could not access this area independently and had to request staff assistance to enter and exit the dining facilities.

Judgment: Substantially compliant

Regulation 8: Protection

All staff had received training in preventing, detecting and responding to abuse, according to a sample of training records seen by the inspectors. Staff spoken with were aware of what constitutes abuse and how to raise concerns with senior management. Residents' finances were being well managed, and the provider was a pension agent to some residents in the centre. Inspectors were satisfied that there

were robust systems in place to manage residents finances and pension agent agreements were in place between the provider and the residents. There was support from a centralised finance team as well as internal administration staff to support these services.

Judgment: Compliant

Regulation 9: Residents' rights

The following required action to ensure residents rights were upheld in the centre:

- The inspectors were informed of some inappropriate staff practices on the day of inspection. For example: some high dependency residents on a number of floors were routinely being awoken very early (from 5.30am) to get washed and dressed, with a number of residents having had their breakfast before 6.30am. Inspectors were informed that this practice was mainly to facilitate day staff coming on duty.
- Although activities had been reviewed following the findings of the previous inspection, findings of this inspection were that arrangements had not been made to provide residents on the 2nd and 3rd floor with consistent opportunities to participate in actives in accordance with their interests and capacities.
- Although there was a dining room on each floor of the centre, seating was limited and could not accommodate 111 residents. Therefore, there was not an opportunity for all residents living in the centre to have a choice with regards to use of these dining facilities and access to a dining experience. On some floors a large number of residents were seen to eat in their bedrooms or in the lounge area where they spent the day.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Carechoice Montenotte OSV-0000253

Inspection ID: MON-0047818

Date of inspection: 29/07/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • A comprehensive review of current practices and management structures on each unit is underway to ensure appropriate levels of staff supervision. This will ensure residents receive adequate assistance, particularly during mealtimes. • During safety huddles, staff have been reminded of the importance of ensuring residents are optimally positioned to facilitate safe swallowing and prevent complications. In addition, IDDSI refresher training is being rolled out for all staff. • Management team will supervise mealtimes and conduct spot checks to reinforce good practices, with particular focus on gaps identified during the inspection. • The working practices noted around residents being woken up early to be washed and dressed has immediately ceased. The focus continues to be on respecting each resident's personal preferences regarding wake-up times and mealtimes, thereby promoting autonomy and choice. • Staff have been re-educated on residents' rights and the importance of respecting individual routines and preferences. Human Rights and Safeguarding training is underway, with full staff completion due by 31st of October. • All care plans are under review to ensure that residents' preferences around bedtime are clearly recorded. Staff are reminded of their responsibility to follow care plans when delivering care. • Issues related to medication management have been addressed. All nursing staff will receive onsite re-training in safe medication management practices, in line with Nursing Professional Guidelines and the "10 Rights of Medication Administration." • Staff nurses have been reminded that all medications must be administered in accordance with the centre's Medication Management Policy. All nurses are expected to adhere fully to NMBI standards and professional guidance when administering medicines to residents.	

Regulation 23: Governance and management	Not Compliant

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

• A support team has been established to review current structures and processes, with a particular focus on strengthening staff supervision. This includes oversight of residents' nutritional needs, medication management, and the protection of residents' rights.

• Staff meetings have been conducted across all units to ensure clear and consistent communication. A regular meeting schedule is now in place. Clinical governance and departmental meetings continue, with frequent updates provided to staff on new practices and changes in care delivery. The emphasis remains on person-centred care, respecting residents' rights, and promoting autonomy.

• Daily staff huddles are now being used as a platform for informal education and communication, incorporating toolbox talks to reinforce best practices, promote learning, and address emerging issues in a timely manner. These measures support a more open, communicative, and proactive team environment focused on quality and safety in resident care. Any concerns raised during these huddles are escalated to the Clinical Management Team for follow-up.

• A full compartmental evacuation drill for the largest compartment with the lowest staffing levels has been scheduled for 17/09/2025. Fire safety training is completed annually by all staff.

• A full review of fire evacuation procedures is underway. A plan is in place to conduct regular evacuation drills, with learning outcomes from each drill discussed during staff meetings. These outcomes will also be integrated into ongoing fire safety training to reinforce best practices and address any identified gaps.

Regulation 17: Premises	Substantially Compliant

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

• The heating system installed is supported by a Building Management Software System which is designed to regulate internal air temperatures, to set points ,as recommended by the guidelines.A Specialist subcontractor whom services the system has been requested to re-attend , to service and reappraise the system settings, especially during very warm periods which will ensure that all residents are comfortable in their environment.

• As a secondary measure additional temperature and humidity data loggers will be installed across all areas within the Home which will be linked to the PIC and clinical management team, this will provide accurate monitoring of and control temperatures and allow the PIC and clinical management team to act as appropriate .

• Part of this measure especially in very warm conditions were heating has been reduced, portable air conditioning units will be provided to those areas and residents which are deemed uncomfortable. Additionally, Doors and windows are also being opened to increase natural ventilation.

• The reconfiguration of the dining room on Roches Point will be completed to enhance the residents' overall dining experience.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• Staff have been re-educated on the gaps noted during the inspection, with emphasis on the importance of accurate food and fluid intake documentation. Nurses will monitor records daily to ensure accuracy, supported by spot checks and care record reviews carried out by the Clinical Management Team.

• Clear protocols have been established for staff to report poor intake to the Staff Nurse promptly. Maintaining accurate intake records is essential for identifying changes in nutritional status, supporting clinical decision-making, and ensuring timely interventions. These records will be monitored on a daily basis.

• Care plans will be reviewed and updated to include details such as residents requiring assistance at mealtimes, those who prefer to dine in their rooms, residents at high risk of weight loss, individual likes and dislikes, and specific dietary requirements. Mealtime supervision is now a standard part of nursing oversight, with additional oversight provided by the Clinical Management Team.

• Staff allocation is reviewed daily to ensure sufficient staffing levels and appropriate allocation of duties for mealtime support. Mealtimes are supervised by the management team, and any gaps noted are addressed in real time.

• Resident feedback on the mealtime experience is obtained through surveys, direct feedback, and resident meetings. Any areas identified for improvement will inform a targeted quality improvement plan.

• The governance team and senior management conduct regular floor walks to observe practices, engage with staff and residents, and follow up on any actions with the DON to ensure the service is effectively managed.

• A support team comprising experienced senior staff from within the organisation has been allocated to assist the local team in reviewing dining experiences, improving practices, providing staff education, and supervising care delivery.

• Recruitment is underway for Clinical Nurse Managers to increase staff supervision and strengthen oversight across all floors.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• A full review of medication administration practices has been completed to ensure compliance with the "10 Rights of Medication Administration" and Nursing Professional Guidelines.

• All medications prescribed to be crushed have been reviewed in collaboration with the pharmacist and management team to confirm their suitability. A comprehensive medication audit has also been completed by the pharmacist. Refresher training on safe medication administration is currently being delivered onsite to all nursing staff.

• Staff nurses have been reminded that all medications must be administered in line with the centre's Medication Management Policy. All nurses are expected to adhere strictly to NMBI standards and professional guidance when administering medicines to residents.
• There is an increased ADON presence on the floor to supervise medication management practices. All nurses complete a medication competency assessment as part of their induction, with reassessment conducted as required.
• Immediate supervision of medication practices has commenced, and a full review is underway. The staff nurse identified in the incident report has been met with, an investigation was carried out, and an action plan has been implemented. This includes retraining and a reassessment of medication competency.

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:
• All restrictive practices will be reviewed to ensure compliance with the centre's policy and the national restraint policy guidelines. Reviews will confirm that only the least restrictive option is used, supported by clear risk assessments and a documented rationale for any restraint usage.
• Residents are reassessed every four months, or more frequently if required, through a multidisciplinary approach. This ensures that restraints are applied only when absolutely necessary for safety or well-being, and always in line with the resident's care plan.
• Staff will receive additional training on the appropriate use of restraints, including documentation requirements and the ethical considerations involved.
• All residents' care plans have been reviewed and updated. Each resident now has a behavioural support plan in place, incorporating specific, evidence-based de-escalation strategies tailored to their known triggers, preferences, and communication needs. Nursing and care staff have been re-educated on documentation gaps. The CMT will review behavioural support plans as part of the weekly behaviour KPI review and the monthly site report review.
• The dining room on Roches Point has been unlocked and is now freely accessible to residents, with risk assessments in place to ensure resident safety. Resident access to all areas within the centre will be monitored to ensure safe and unrestricted access at all times.
• Ongoing monitoring of restrictive practices and behavioural support plans has been incorporated into weekly audits, with outcomes reviewed at governance meetings to ensure sustained compliance.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• All previously identified inappropriate care practices have been immediately ceased. Senior management and governance teams are reviewing all related processes and structures to ensure the safe, respectful, and person-centred delivery of care.
• Staff are receiving refresher training on residents' rights, dignity, and choice, reinforced through team huddles, supervision, and Human Rights/SVP training.
• The activity schedule has been revised to allocate staff and resources across the 2nd and 3rd floors, with oversight from the Activity Coordinator and ADONs. The Senior Management Team is reviewing the overall activities programme, including the range and quality of activities, and restructuring staffing hours on each unit to enhance resident engagement.
• In consultation with residents, there will be additional Social Activity with focus on Dining Experience. Residents will have an opportunity to experience joined dining in additional dining space on weekly basis with the plan to increase number of events as per residents' preferences.
• The dining experience is under evaluation to ensure all residents can access the dining room in line with their personal choice and preferences. This includes a full review of dining facilities on each unit to improve comfort and accessibility.
• Ongoing monitoring of residents' rights, activities, and the dining experience has been integrated into supervision and local audit schedules, with findings reviewed at clinical governance meetings.
• Resident feedback and care outcomes are monitored through surveys, comments, and complaints. This information is used to evaluate the impact of changes and to drive continuous improvement.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in	Substantially Compliant	Yellow	30/11/2025

	accordance with the individual care plan of the resident concerned.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	31/10/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/10/2025
Regulation 23(2)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	31/10/2025
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in	Not Compliant	Orange	31/10/2025

	accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
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	15/11/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/10/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/10/2025