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: | St Joseph's Hospital |
| Name of provider: | Bon Secours Health System CLG |
| Address of centre: | Mount Desert, Lee Road, Cork, Cork |
| Type of inspection: | Unannounced |
| Date of inspection: | 31 March 2026 |
| Centre ID: | OSV-0000284 |
| Fieldwork ID: | MON-0049928 |

## About the designated centre

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

St Joseph's Hospital, Mt. Desert is a purpose-built designated centre situated in the rural setting of the Lee Road, Cork city, a short distance from Cork and Ballincollig. It is registered to accommodate a maximum of 103 residents. There is a large comfortable seating area and main 'Village Green' restaurant dining room at the main entrance. Communal areas include the Beech room which facilitates functions, the large activities room and Chapel, and occasional resting areas along corridors for residents' relaxation. Bedrooms accommodation comprises five twin bedrooms and the remainder are single occupancy; all with full en suite facilities of shower, toilet and wash-hand basin, with additional toilet facilities throughout the centre. Accommodation is set out in four wings: 1) Daffodil: 26 bedded unit with two living rooms and seating areas with direct access to the secure garden, and the Patel room dedicated private family room 2) Bluebell: 26 bedded unit with a living room and glass seating area 3) Lee View: 26 bedded unit with living room, two glass seating areas with direct access to the secure garden 4) Woodlands: 25 bedded unit with two living room. St Joseph's Hospital, Mt. Desert provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, respite, convalescence and palliative care is provided.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 103 |

## 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 31 March 2026 | 15:55hrs to 20:45hrs | Louise O'Hare | Lead |
| Wednesday 1 April 2026 | 08:45hrs to 17:25hrs | Louise O'Hare | Lead |
| Tuesday 31 March 2026 | 15:55hrs to 20:45hrs | Ella Ferriter | Support |
| Wednesday 1 April 2026 | 08:45hrs to 17:25hrs | Ella Ferriter | Support |

## What residents told us and what inspectors observed

This was an unannounced risk inspection carried out over one evening and one day by two inspectors. The inspection was triggered in response to unsolicited information submitted to the Office of the Chief Inspector in relation to staffing shortages, care deficits and residents' rights being impacted. Both inspectors spent time over the two days observing care practices and staff interactions with residents, as well as speaking to residents, staff and visitors. Residents who spoke with inspectors said that they were happy to be living in the centre and found it a very comfortable and pleasant environment. Some residents told inspectors that staff were kind, good to them, and they worked hard. However, other residents told the inspectors that staff were very busy, there were recent shortages of staff and this had resulted in delays in answering call-bells and providing assistance.

St. Joseph's Hospital is a purpose built designated centre for older people, located a short distance from Cork city and the town of Ballincollig. On the day of inspection, it was fully occupied, with 103 residents living in the centre. The centre was divided into four units: Daffodil, Bluebell, Lee View and Woodland. Accommodation was comprised of 93 single rooms, and five twin rooms, all of which had en-suite facilities. Residents' bedrooms were clean, bright and personalised. Bedrooms were each equipped with a call-bell, television and seating, and there was sufficient closet space, display space and storage for personal items. Some residents had decorated their bedrooms with pictures, ornaments, plants and furniture from home. Both residents and visitors spoke very highly of the premises and one resident described the centre as a home away from home. Inspectors observed that all bedrooms were cleaned and maintained to a high standard, and that, since the previous inspection, flooring had been replaced in a number of bedrooms.

Residents had access to several communal areas including areas for sitting and dining located in each unit. In addition, there was a large activities room, restaurant and chapel. The restaurant was bright, with lovely views into the surrounding gardens. Inspectors observed that this was used throughout the day and was a pleasant social space for residents to enjoy with their visitors. The spacious interfaith chapel was well-decorated and provided a peaceful space for residents. Mass was held in the chapel six days a week at 11.30am, and many residents expressed their appreciation of the frequency of religious services. The secure internal gardens were planted with shrubs and flowerbeds, and the inspectors saw that they were well-maintained and easily accessible. Residents were seen to enjoy being out and about in the gardens during the inspection, and both visitors and residents commented on how much they enjoyed them.

During the inspection, inspectors greeted several residents and spoke to 28 in more detail to gain an understanding of their lived experience. One resident described the centre as a "great place to live", another described the staff as "very attentive" and one told the inspector "they take good care of us". However, residents also

described the centre as being short staffed, staff as very busy and stated that sometimes they had to wait for care. Some residents had been informed by staff that delays in answering call-bells was a result of staffing issues and residents told the inspectors that they were used to having to wait. Residents told inspectors that they had not been informed about changes to staffing levels by management. Some residents commented that there were many "new faces coming and going", that it took time for them to get to know new staff, and sometimes these staff did not know their care preferences. One resident also told inspectors that there were sometimes issues with the supply of incontinence wear, and that as a result they had to wear the incorrect size.

Residents told inspectors that they had made their concerns and dissatisfaction known to staff. Some further residents told inspectors that they were dissatisfied with the response to their verbal feedback. For example, two residents told inspectors that they noted there were more agency staff recently and this was difficult as they did not know their care preferences, such as what time they would like to get up. Discussions with residents indicated that their concerns had been brought to management; however, they were not satisfied that they were always acted on.

Inspectors also spoke with six visitors, and while most spoke highly of the staff and care in the centre, some told the inspector that the centre was short staffed and they had noticed their relatives waiting longer to receive care.

Inspectors observed staff and resident interactions throughout the day, and found that overall they were kind and respectful. From speaking to staff, it was evident that they were committed to their work, and to delivering a high standard to care to residents in line with the ethos of the Bon Secours. Residents were exceptionally complimentary about the activities and activity co-ordinators. The weekly calendar of activities was displayed throughout the centre, and included coffee mornings, Easter celebrations, dancing, music and board games. Residents told the inspectors that there was always something to do and something to look forward to. A number said they enjoyed the group activities and others preferred the one-to-one activities. Residents and relatives both spoke highly of the variety of activities and told inspectors that they loved all the music, bingo and art.

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

## Capacity and capability

Findings of this inspection, were that management systems in place did not provide effective oversight to ensure that the service provided to residents was safe, consistent and appropriately monitored. Action was required to comply with the

regulations in regards to staffing, complaints management, supervision of care delivery, maintenance of record systems, and the overall governance and management of the service. These findings will be detailed under the relevant regulations in this report.

As mentioned in the previous section, this risk inspection was carried out in response to unsolicited information received in regards to staffing levels in the centre. Following on from the receipt of this information, a cautionary meeting was held with the registered provider on the 17th February 2026, where commitments were given regarding the monitoring and oversight of the impact of the reduction in staffing levels on residents. Further commitments, outlining a plan to enhance the governance arrangements in regards to staffing and supervision, were received in a written assurance report from the provider on the 13th March 2026. However, findings of this inspection were that the provider had not implemented many of the actions they had outlined and inspectors were not assured with regards to the allocation of staffing resources, and supervision and monitoring of care delivery.

Bon Secours Health System CLG is the registered provider for St. Joseph's Hospital. The management structure was comprised of the board of management, the chief executive officer and the senior management team. The person in charge had been in post for over two years, and was supported at a senior management level by the group's head of Quality and Risk, who was named as a person participating in management (PPIM). Additionally, two further members of the senior management team had been named as PPIMs, to provide management support to the centre. Associated notifications had been submitted, as required by regulations, and were in review at the time of inspection. At an operational level, the person in charge was supported in their role by an assistant director of nursing, and a team of clinical nurse managers, registered nurses, healthcare assistants (HCAs), activities co-ordinators, maintenance, catering and administrative staff. The person in charge and the assistant director of nursing supervised care delivery and were supernumerary when on duty Monday to Friday. There was a clinical nurse manager on duty at the weekends.

An annual review of the quality and safety of care delivered to residents in 2025 had been completed, and a quality improvement plan had been developed to address issues such as medication management. Governance meetings were scheduled monthly, to review matters including complaints, incidents, human resources and finance. The registered provider had systems in place to monitor the quality and safety of care via an audit system. Key clinical indicators with regard to the quality of care provided to residents were collected on a weekly basis and collated to develop a monthly report that was submitted to the senior management personnel to support oversight of the service. This included the incidence of wounds, restrictive practices, falls, and other significant events. However, inspectors found that these systems had failed in so far as they did not identify the deficits in the quality and safety of resident’s care that this inspection found. Areas of particular concern included staffing, communication and the supervision of care delivery.

Overall, there were inadequate systems in place to monitor the ongoing quality and safety of the care delivered to residents. Inspection findings were that there was not

sufficient oversight of the day-to-day operation of the centre, by the management team, to ensure that issues identified for improvement on this inspection were captured through the centre's own audit process. Auditing was found to be inconsistent and was not being used to drive quality improvement within the centre. This is further detailed under Regulation 23: Governance and Management.

As mentioned, the provider had implemented a reduced staffing model, specifically the amount of healthcare assistants working on each of the four units. From discussions with staff and a review of staff rosters, it was evident that each unit was rostered to have two staff nurses and three HCAs or one nurse and four HCAs per day, to care for up to 26 residents. Night-time staffing levels were unchanged, since they had been increased by the provider in 2023. Findings of this inspection were that inspectors were not assured that the number and skill-mix of staff working in the centre was adequate, when considering the high dependency needs of residents and the size and layout of the centre. The reduction in staff had a negative impact on the delivery of residents care. This finding is further detailed under Regulation 15: Staffing.

The person in charge had ensured that staff had access to, and were facilitated to attend, a range of training programmes to support them in delivering care to residents. This included training in the IRESTORE programme (a early warning system to detect acute clinical deterioration in older adults living in residential care), which had been completed and a plan was in place to implement this in the centre. Mandatory training was largely up-to-date and the inspectors saw that further training had been scheduled in the coming weeks to ensure all staff were current. However, inspectors were not assured that appropriate staff supervision arrangements were in place as supervision of care delivery was not adequate and did not ensure that residents' rights were upheld. These practices had not been recognised, monitored or addressed by the management team, as set out under Regulation 16: Training and staff development

Findings of this inspection were that there were ineffective communication and monitoring systems in place to ensure service delivery to residents was safe and effective. For example, from speaking to residents, visitors and staff, inspectors found that some incidents and complaints were not communicated to the management team to ensure they could be addressed in a timely and consistent manner. This is detailed under Regulation 23: Governance and management.

The complaints management procedure was displayed in the centre, in line with the regulations. Inspectors reviewed a sample of complaints records which showed that those recorded were investigated and managed in line with this. However, action was needed to ensure all complaints were recognised as such, as detailed further in Regulation 34: Complaints procedure. The monitoring and recording of incidents was not sufficient, and records were found to be incomplete. For example, three medication errors which occurred in the centre had not been investigated appropriately and this system did not effectively identify areas that required to be addressed. This is detailed under Regulation 21: Records.

## Regulation 15: Staffing

As referenced earlier in this report, the provider had recently reviewed staffing levels, specifically this related to a reduction of health care assistants on each unit. On the days of this inspection, inspectors were not assured that staffing levels were appropriate to meet the assessed needs of residents, as evidenced by:

- Feedback from residents on the days of inspection indicated that there were reported delays in care delivery, with residents describing delays from 15 to 40 minutes.
- Residents also reported changes in staff practices, such as scheduling showers for specific days, and night staff being asked to assist residents with their personal care early in the morning, this did not respect residents' rights.

In addition, residents' dependency levels in the centre were not sufficiently monitored, and therefore not used to ensure staffing resources could be effectively planned and allocated in the centre. For example, every unit had the same staffing allocation; however, there were discrepancies in the dependency levels between units.

Judgment: Not compliant

## Regulation 16: Training and staff development

The registered provider had inadequate arrangements in place to ensure appropriate levels of staff supervision to ensure that care delivery was appropriately monitored and delivered. This lack of staff supervision, monitoring and support had a direct negative impact on the delivery of health and social care to residents. This was evidenced by:

- Multiple residents reported waiting long periods of time for their call-bells to be answered. In addition, on the answering of the bell residents would have to wait a further period of time for their request to be attended to.
- Care staff were not appropriately supervised to ensure that care was delivered in line with residents' requests and choice. For example; resident's care delivery was determined by the duties of the healthcare staff as opposed to the resident's preference.
- Where agency staff were rostered there was no evidence of an induction checklist being completed in line with the centre's policy. Residents reported to inspectors that agency staff were unfamiliar with their care preferences.

Judgment: Not compliant

## Regulation 21: Records

Some record-keeping and file-management systems were not appropriately maintained, for example:

- Some incident records were incomplete and not documented in line with the centre's own policy, and they did not contain the detail required by Schedule 3(4)(j) of the regulations.
- Records of current registration details of registered nurses were not available for review, as required by Schedule 2(4).

Judgment: Substantially compliant

## Regulation 23: Governance and management

Management systems were not sufficient to ensure that the service provided was safe, appropriate, and consistently monitored, evidenced by the following findings:

- Communication systems were not sufficiently robust. For example, the systems in place for staff to report incidents such as skin tears and accidental injury to residents was insufficient. This resulted in delays in management being made aware of these incidents.
- When audits identified issues with service delivery, the inspectors saw that action plans were not consistently developed or implemented to address the identified areas for improvement.
- The provider had committed to completing observational audits of call-bell response times, care delivery and manual handling practices, in conjunction with the change in the centre's staffing model. However, these systems had not been developed or implemented at the time of this inspection and were not available for review.
- There was an insufficient system in place to monitor residents' dependency levels in the centre and inadequate oversight of this by management. This is required to ensure staffing resources could be effectively planned and monitored.
- There was not appropriate oversight and investigation of incidents occurring in the centre, this is to ensure that contributing factors were identified and learning could be disseminated amongst staff.
- Supervision of staff was not adequate as detailed under Regulation 16: Training and staff development.
- The management systems in place to recognise and respond to complaints did not ensure that residents complaints were acted upon in a timely manner. This is further detailed under Regulation 34.
- The registered provider had not ensured that there were effective arrangements in place to facilitate staff to raise concerns about the quality

and safety of care and support provided to residents, as required under Regulation 23(2).

Judgment: Not compliant

## Regulation 31: Notification of incidents

The person in charge ensured that notifiable incidents were submitted in writing to the office of the Chief Inspector in a timely manner.

Judgment: Compliant

## Regulation 34: Complaints procedure

While complaints that were documented were investigated and managed in line with the centre's policy, some action was required as evidenced by:

- When a written response was given, it did not include details of the review process as required by the regulations.
- From speaking to residents and family members, inspectors were not assured that all complaints were being recognised as such. For example, concerns raised in relation to delays in care delivery. This impacted on the timely review and resolution of complaints, as well as learning from complaints.

Judgment: Substantially compliant

## Quality and safety

Findings of this inspection were that residents were supported to have good access to healthcare services and opportunities for meaningful activities in St Joseph's Hospital. However, the deficits in the governance and management systems, as described in a previous section of this report posed a risk to the delivery of a safe and high quality service. Action was required pertaining to residents rights and care planning as detailed below.

Resident care records were maintained on an electronic care record system. Following admission, a range of clinical assessments were carried out using validated assessment tools to identify areas of risk specific to each resident. The outcomes of these assessments were used to develop an individualised care plan,

which addressed their individual abilities and assessed needs. All residents had a care plan in place as per regulatory requirements. However, some care plans were not sufficient to guide care and were not effectively communicated to staff as detailed under Regulation 5: Individual Assessment and Care Planning.

Residents had good access to General Practitioner (GP) services, who visited the centre regularly. There were established pathways for referral to a team of health and social care professionals for additional expertise and review. This included mental health services, geriatrician services and dietetics. A review of residents' records found that treatment plans by GP's and health and social care professionals were incorporated into residents' care plans, which were seen to improve resident outcomes. For example, the advice and expertise of specialist wound care nurses was implemented, and resulted in uncomplicated wound healing. Where a resident had been transferred to a hospital, inspectors noted the appropriate sharing of relevant information about the resident with the receiving hospital to support the safe transfer of care.

The registered provider had ensured that the premises was decorated to a very high standard, and inspectors observed that the premises was bright, well-maintained and visibly clean throughout. Since the previous inspection, flooring in a number of residents' rooms had been replaced, and the inspectors saw documentation that maintenance issues were discussed and actioned on an ongoing basis.

Residents praised the range and availability of activities in the centre. Activities co-ordinators were scheduled seven days a week from 09:45hrs to 19:00hrs. One the first evening of inspection, inspectors observed residents enjoying bingo. While, on the second day of inspection, inspectors observed residents enjoying tea, coffee and chatting with activity coordinators, participating in a dance session and later a lively sing along. The activities room was well-equipped and included an area that was dedicated to exercise equipment for residents' use. Residents were well-supported to exercise their religious rights, and also had access to newspapers, radio, television and other media. Information on independent advocacy services was displayed in the centre. Residents' meetings took place regularly; however, the inspectors found from a review of meeting minutes, and from speaking to residents, that they had not been consulted about the recent changes in staffing. This is detailed under Regulation 9: Residents' rights.

## Regulation 17: Premises

The provider had ensured that the premises were appropriate to the number and needs of the residents in the centre, and conformed to the matters set out in Schedule 6 of the regulations.

Judgment: Compliant

## Regulation 25: Temporary absence or discharge of residents

Arrangements were in place to ensure that the transfer of residents from the designated centre to hospital, or other health care services, occurred in line with the requirements of the regulations. This included arrangements to ensure information pertinent to the care of residents were communicated to the receiving health care facility.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

While care plans were developed in a timely manner, action was required as:

- Moving and handling care plans were not effectively communicated to staff, as evidenced by two care plans which did not match the moving and handling guidance displayed in residents' rooms. This could lead to errors in care and create a risk to residents.
- Two residents' files reviewed indicated that they were at high risk of choking. However, a review of their care plans showed that for one this risk was not referenced and for the other it stated "supervise if possible". This lack of clear information did not direct care and posed a risk to residents.
- Some care plans did not reflect residents' preferences for the gender of staff providing personal hygiene, which did not ensure their rights were reflected and respected.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents had good access to appropriate medical care. GPs visited the centre regularly and were further supported by specialist geriatrician and mental health services. Records showed that residents had access to a range of health and social care professionals including physiotherapy, occupational therapy and specialist wound care nurses. Recommendations and treatment plans were incorporated into residents' care plans, and the inspectors saw records that this improved outcomes.

Judgment: Compliant

## Regulation 8: Protection

There was an up-to-date policy in place to guide staff in detection and prevention of abuse, and staff received training on safeguarding and caring for residents with responsive behaviours.

Judgment: Compliant

## Regulation 9: Residents' rights

Although it was evident to inspectors that residents' rights were a central part of the ethos of service delivery in St. Joseph's Hospital, inspectors found that the recent change of staffing model had impacted rights, as evidenced by:

- Inspectors were not assured that residents were appropriately consulted and facilitated to participate in the organisation of the designated centre as required by the regulations. Specifically, where changes had been made operationally in relation to staffing resources there was no evidence that residents had been informed of this.
- Residents told the inspectors that there were delays in care, and this impacted their ability and choice to receive personal care in line with their preferences, and at a time of their choosing.

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 | Not compliant |
| Regulation 16: Training and staff development | Not compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Compliant |
| Regulation 25: Temporary absence or discharge of residents | Compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Substantially compliant |

# Compliance Plan for St Joseph's Hospital OSV-0000284

## Inspection ID: MON-0049928

## Date of inspection: 01/04/2026

**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 | Not Compliant |

Outline how you are going to come into compliance with Regulation 15: Staffing:

The registered provider acknowledges the findings of the inspection and is committed to ensuring that staffing levels and skill mix are appropriate to meet the assessed needs of all residents.

A validated dependency assessment process is in place across all units. This includes the use of the Barthel Assessment to evaluate residents' functional ability and level of dependency. In addition, a tool is utilised to calculate the care hours required based on assessed dependency levels. This combined approach supports the determination of appropriate staffing levels and skill mix to meet residents' needs.

In addition to the use of the tool, the registered provider uplifts staffing requirements by an additional 20% to cover for annual leave, training, design and layout of the centre.

To date, these tools have been utilised to inform staffing levels within the centre. The tool is applied on a unit-by-unit basis to calculate the care hours required in line with assessed dependency levels. This ensures that staffing resources are appropriately aligned with the specific needs of residents in each unit. The registered provider is committed to ensure staffing levels reflect the dependency level on each unit, and not all units will have the same staffing levels due to variations in dependency levels per unit, this will be evidenced by customised unit rosters based on dependency within that unit.

As a result of the inspection findings, the registered provider has put the following in place:

1. A weekly management meeting is now operational, led by the Person in Charge (PIC) to review rosters, skill mix and dependency levels for the week ahead. Where dependency levels have changed, the Assistant Director of Nursing (ADON) and PIC have the authority to change / adapt rosters to reflect staffing / dependency appropriate requirements.

2. Membership of this weekly management meeting consists of the PIC, ADON and 4 x CNM's or delegate as appropriate.
3. At this weekly management meeting, the following key performance indicators, in addition to the staffing/dependency review above, are reviewed to assess whether further action is required:
a. Number of incidents per unit
b. Contributory factors per incident
c. Number of complaints, feedback, cause for concerns raised
d. Call bell response times
e. Review of the previous weeks use of agency staff if any
f. Number of preassessments / new residents arriving

The registered provider confirms that, based on current dependency assessments, staffing levels are in line with assessed needs. Notwithstanding this, the centre has experienced six recent staff resignations, which have had a temporary impact on staffing stability. In response, a targeted recruitment campaign is currently underway to address these vacancies and strengthen the staffing complement.

The targeted recruitment campaign has attracted a number of staff nurse, HCA and Clinical Nurse Manager (CNM) applicants, who are currently progressing through the recruitment process. It is anticipated that these appointments will significantly enhance staffing levels and skill mix, thereby addressing the concerns identified during the inspection.

The registered provider has identified that sick leave in the centre is higher than the expected sick leave norm. This along with the six resignations and Influenza and Norovirus outbreaks in January and April compounded staffing levels. As a result of this, the following initiatives are underway:
1. In addition to the six resignation posts being replaced, the registered provider has advertised for a bank HCA panel to support staffing on an "if and when required" basis. This initiative is intended to reduce and ultimately eliminate reliance on agency staff during periods of staff shortages, while improving continuity and familiarity of care for residents.
2. A HR business partner role has been advertised, to support the centre to manage absenteeism.
3. Occupational Health resource has been set up for staff absenteeism.
4. A vacancy approval panel has also been establishment to facilitate the timely filling of future vacancies. The vacancy approval panel meets once a week and consists of the Person in Charge or ADON in their absence, Persons Participating in Management, Human Resources and others.
In the interim, when agency staff are required, the provider has taken the following actions:
1. The registered provider has requested that specific agency staff be assigned consistently to the centre to promote familiarity for residents.
2. The Assistant Director of Nursing (ADON) provides oversight and follows up with all residents who have been cared for by agency staff to ensure care has been delivered in line with their care plans. In the absence of the ADON at the weekend, this responsibility is delegated to the Clinical Nurse Manager (CNM) on duty.
3. The agency induction has been reviewed, with checklists now in place to ensure

agency staff are fully informed of residents' needs, care plans, and centre-specific practices.
4. A structured system for monitoring call-bell response times is being implemented, with a target response times <5 minutes being set. Weekly call-bell reports are generated and audited by the Person in Charge (PIC), with oversight and escalation procedures in place to support timely responses and ongoing quality improvement.
5. Residents and Relative/family surveys have been introduced to track anonymised feedback from residents and their families and identify areas of concern and further improvement. These surveys will be reported into governance on a bi-annual basis going forward.

| | |
|---|---|
| Regulation 16: Training and staff development | Not Compliant |

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

The registered provider acknowledges the findings of the inspection and is committed to ensuring that all staff are appropriately supervised in their roles. Following the inspection, the registered provider is reviewing the implementation of the following actions:

1. Supervision arrangements within the center are delivered via the established management structure, comprising of the PIC, ADON and CNM's, who provide oversight and support to staff in the delivery of care. In order to ensure senior nursing leadership and oversight, the registered provider is assessing the move to a 5-day CNM roster to ensure more senior leadership is available.

2. Competency assessment tools are being revised and re-developed for all staff working across the nursing home, to ensure there are no gaps in skills across the centre.

3. The providers current comprehensive induction programme is being revised. This will be provided to all new employees to ensure that they are appropriately familiarised with the centre, its policies and its residents.
4. Daily walk arounds have been implemented, led by the PIC or ADON in their absence. Any issues identified are dealt with on the walkaround, and addresses at the weekly management team meeting, to ensure learning and improvement. These meetings also include a structured review of key performance indicators (KPIs) at unit level, including staffing, dependency, care delivery, incidents, complaints, safeguarding, and quality and safety metrics. Actions arising are recorded, assigned, and monitored to completion.
5. The registered provider has implemented a Relative / Family Satisfaction survey, in addition to a resident satisfaction survey. These surveys are anonymous and will be conducted twice a year.

6. A care planning workshop is set up for 13 May 2026, to review residents care plans and address any deficits to ensure care is delivered in line with residents' assessed needs, preferences, and care plans.

7. A review of the audit program across the center is under way, incorporating both clinical and environmental audits, including care planning, documentation, responsive behaviour, safeguarding and infection prevention and control. A revised audit policy and governance structure will be established following the completion of this review, to ensure appropriate oversight, monitoring and continuous quality improvement.

8. A call bell response time monitor has been set up, with reports being generated and reviewed by the PIC at the weekly management meeting. All call bells response times >5 minutes will be raised as an incident for monitoring and trending purposes, in addition to establishing reasons for the delay in response times. This supports oversight of responsiveness to residents, with any identified delays or trends escalated to the management team for timely action.

9. As part of the weekly management meeting, any updates to residents' preferences and care plan updates are reviewed and addressed.

10. An induction program for agency staff is in place and operational. An induction checklist is used by the CMN on duty as a guide on the commencement of duty, to ensure familiarity with residents' needs, care plans, and centre-specific practices. In addition, the ADON carries out daily oversight to ensure compliance with induction requirements and safe, consistent care delivery. The auditing of agency checklist compliance will be added to the European Compliance' officer matrix of checks, as part of the annual internal compliance audit.
11. All staff complete Human Rights-Based Approach to Care modules to support their understanding of residents' rights, dignity, autonomy, and choice. Further training has also been confirmed titled 'Human Dignity and Respect', which is a staff engagement program and Workplace Culture Initiative, to strengthen a culture of human dignity, respect and positive working relationships. Focus Group are taking place over the month of May 2026, with attendance of just over 50 staff to date. See page 7 of this document for further information (Regulation 34.2)

| | |
|---|---|
| Regulation 21: Records | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 21: Records:

The registered provider acknowledges the findings of the inspection and will ensure that all records are maintained in accordance with regulatory requirements and are available for inspection.

Whilst the registered provider had performed electronic validation that all nursing staff were registered with NMBI prior to the inspection, the provider will ensure that hardcopy certificates are available onsite going forward for inspection.

Incident reporting is currently managed through the centre's electronic health record system. To strengthen oversight and ensure compliance with Schedule 3 requirements,

the following action plan is being implemented:

1. A workshop on incident importance of recording incidents will be provided to all staff, along with a training program to ensure consistency and quality.
2. Training has begun with the provider of the Resident Electronic Health Record to produce reports on care planning, complaints, incidents and risks to provide greater oversight.
3. All incidents will be reviewed at the weekly management team meeting, with a breakdown of incidents, contributory factors and lessons learned reported into the clinical governance committee on a monthly basis. Where gaps or inconsistencies are identified, these will be addressed promptly, and findings will inform a targeted education and support plan for staff to improve documentation practices.
4. The incident management policy will be revised as part of this process.

| | |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

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

The registered provider acknowledges the findings of the inspection and is committed to strengthening governance and management systems to ensure that the service is safe, appropriate, consistent, and effectively monitored.

The current Governance arrangements in place within the centre, include electronic incident reporting systems, regular management oversight, and key performance review processes. These will be further strengthened to ensure more effective monitoring, accountability, and timely response to identified risks. In order to achieve this, the following actions have / will be implemented:

1. New weekly management team meeting with PIC, ADON and CNMs has been established. This management team meeting has a standing agenda which includes dependency levels and staffing, incident reporting & learning, notifiable incidents, mandatory training, care plans overdue, complaints.
2. A weekly governance review meeting involving the Person in Charge and Persons Participating in Management (PPIMs) will continue to provide oversight of key areas including incidents, complaints, staffing, and risk management, and will support the monitoring of actions arising from audits and reviews.
3. A daily huddle is also in place at each of the units, with immediate escalation to PIC/ADON when concerns are raised.
4. A senior leadership walkabout consisting of the ADON/PIC has been implemented daily. The purpose of which is to review incidents on each unit, obtain resident feedback, particularly with residents where agency staff have been rostered, observe the provisions of care being delivered and review any concerns with staff.
5. There is currently one Person Participating in Management (PPIM) registered with HIQA. Prior to the inspection, the registered provider had submitted an application to

register two additional PPIMs. Going forward, the PPIM's will be onsite at a minimum every 2 weeks, to participate in the management team meeting, and perform walkabouts, speaking with residents and staff.
6. Incident management training will be delivered to all staff, with additional training for CNM's around notifiable events. As of 05 May 2026, responsibility for the close out of all incidents and complaints will sit with the PIC/ ADON.
7. Resident and family experience survey results will be feedback to each unit manager on a bi-annual basis, with areas of concern identified and quality improvement plans to be implemented.
8. The registered provider is committed to ensuring that effective arrangements are in place to facilitate staff in raising concerns regarding the quality and safety of care and support provided to residents. Re-education and training will take place on the cause for concern and protected disclosure policies, in addition to concerns which can be raised independently through the Ethical helpline or Compliance officer.
9. A monthly staff forum has been established (30 April 2026) to provide a structured platform for staff to raise concerns, share feedback, and contribute to service improvement. This forum is attended by management and supports open communication and transparency. In addition, staff are supported to raise concerns through existing management structures, including direct access to the Person in Charge, Assistant Director of Nursing, and Clinical Nurse Managers. All concerns raised will be documented, reviewed, and acted upon in a timely manner, with feedback provided to staff as appropriate. This will support a culture of openness, continuous improvement, and accountability.
10. Complaints training has been set up for the 20th of July.
11. A review of the audit program has commenced, which will include a revised audit policy and schedule, review of the current audits in place, and transitioning to a more appropriate auditing tool which has a quality improvement plan action tracker. Audit compliance and QIP status will be reported into the clinical governance and performance review meetings on a monthly and quarterly basis going forward.

| Regulation 34: Complaints procedure | Substantially Compliant |
|---|---|

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The registered provider acknowledges the findings of the inspection and will ensure that all complaints are recognised, recorded, and managed in accordance with regulatory requirements.

All staff will receive additional guidance and support to ensure that complaints, including verbal complaints, are appropriately identified, recorded, and escalated in line with the Centre's complaints procedure. The following actions have been agreed for implementation:

1. Complaints training will be provided by an external third-party company on 20th of July 2026.

2. Information on how to make complaint / give feedback will be installed at all nursing stations.
3. A monthly review of all complaint records will be undertaken by the PIC and ADON. This review will include oversight of the nature of complaints, response times, outcomes, and any recurring themes. Findings from this review will be discussed at management and governance meetings, and any required actions will be implemented and monitored to support quality improvement within the centre.
4. A standardised approach to complaint responses will be introduced, to ensure that all written responses include the outcome of the complaint, the reasons for the decision, details of any improvements identified, and information regarding the review process, in line with regulatory requirements.
5. A monthly bulletin per unit will be set up which will include key performance indicators such as falls, medication errors, complaints and resident feedback to ensure staff are aware of what's happening in the unit, and what quality improvement initiatives area in place
6. Additional training on complaints, with a particular focus on human dignity and respect taking place … titled – 'Human Dignity and Respect' Staff Engagement Program – Workplace Culture Initiative.

Overview: A structured programme of staff engagement workshops is being implemented at Mount Desert Care Village to strengthen a culture of human dignity, respect and positive working relationships.
• Programme Design: 11 'required attendance' workshops (80 minutes each) scheduled for all staff.
• Programme commenced on 7 May 2026 and will conclude on 21 May 2026.
• Full staff participation required to ensure consistency of engagement and shared understanding.
• Workshop Structure: Each workshop is delivered in two parts: firstly, a 40-minute presentation delivered by the Head of Mission, covering workplace culture, respect, professional behaviour and BSHS Core Values. This is followed by a 40-minute facilitated discussion providing a structured opportunity for staff to share experiences and perspectives in a safe environment.
• Key Themes Addressed:
o Understanding workplace culture and its impact on staff and residents.
o Building a positive, respectful and inclusive working environment.
o Human dignity and respect in colleague relationships.
o Alignment with BSHS Core Values.
o Themes of justice, equality, fairness and inclusion.
o Professional communication, behaviour and conduct.
o Use of practical examples to reflect on behaviours in daily work.
Staff Engagement and Observations:
• Just over 50 staff have participated to date.
• Sessions described as constructive and appropriately challenging.
• Staff have welcomed the opportunity to have their voices heard.
• Increased awareness of behaviours and workplace culture.
Next Steps:
• External Facilitator report will be compiled following completion of all sessions.
• Report will capture key themes, concerns and staff-identified priorities.
• Outputs will inform Care Village Management recommending targeted actions and

ongoing culture improvement initiatives.
• Focus will remain on strengthening workplace dignity and respect.

| | |
|---|---|
| Regulation 5: Individual assessment and care plan | Substantially Compliant |

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

The provider will ensure that all care plans are comprehensive, individualized, and clearly guide care delivery.

A full review of all residents' care plans will be undertaken to ensure that identified risks, including risks such as choking, are clearly documented and appropriately managed. Moving and handling care plans will be reviewed to ensure consistency with guidance displayed in residents' rooms.

Care plans will be updated to reflect residents' preferences, including preferences relating to personal care. Additional training will be provided to staff to support person-centred care planning and effective communication of care needs.

A workshop has been taken place on 13th May to review the quality-of-care plan documentation with staff and identify areas for audit, in addition to opportunity for improvement.

Reports will be established on the following:
- Care plans due for renewal
- Care plans due to expire
- Care plans reviewed with family

| | |
|---|---|
| Regulation 9: Residents' rights | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The provider is committed to upholding residents' rights and ensuring that residents are actively consulted and involved in the organisation of the centre.

Resident meetings are currently held on a bi-monthly basis, with representation from all departments. These meetings will be enhanced to ensure meaningful consultation, including the inclusion of staffing and service delivery as a standing agenda item.

Management representatives will ensure that any concerns raised are documented, reviewed, and responded to in a timely manner, with actions monitored and followed up at subsequent meetings.

Care practices will be reviewed to ensure that residents' choices and preferences are respected, particularly in relation to the timing and delivery of personal care.

The provider will ensure that residents are kept informed of improvements arising from inspection findings, and feedback will be actively sought to monitor resident satisfaction and confidence in the service.

All staff undertake the following mandatory training to ensure residents rights are respected:
• Applying a Human Rights-based Approach in Health and Social Care: Putting national standards into practice (modules 1-4)
• BSHS Charter of Commitment available throughout care village
• BSHS Mission training

As mentioned above, complaints / concerns training will take place on 20th July to ensure staff awareness on the importance of reporting concerns / verbal complaints / feedback.

## 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. | Not Compliant | Orange | 30/08/2026 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Not Compliant | Orange | 30/06/2026 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. | Substantially Compliant | Yellow | 30/06/2026 |
| Regulation 23(1)(d) | The registered provider shall | Not Compliant | Orange | 31/05/2026 |

| | | | | |
|---|---|---|---|---|
| | ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | | | |
| 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. | Not Compliant | Orange | 30/06/2026 |
| Regulation 34(2)(c) | The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process. | Substantially Compliant | Yellow | 20/07/2026 |
| Regulation 34(7)(b) | The registered provider shall ensure that all staff are aware of the designated centre's complaints procedures, including how to | Substantially Compliant | Yellow | 20/07/2026 |

| | | | | |
|---|---|---|---|---|
| | identify a complaint. | | | |
| Regulation 5(1) | The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2). | Substantially Compliant | Yellow | 30/06/2026 |
| Regulation 9(3)(a) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents. | Substantially Compliant | Yellow | 30/06/2026 |
| Regulation 9(3)(d) | A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned. | Substantially Compliant | Yellow | 30/06/2026 |