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:	Phoenix Park Community Nursing Units
Name of provider:	Health Service Executive
Address of centre:	St Mary's Hospital, Phoenix Park, Dublin 20
Type of inspection:	Unannounced
Date of inspection:	31 March 2026
Centre ID:	OSV-0000476
Fieldwork ID:	MON-0050083

About the designated centre

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

Phoenix Park Community Nursing Units can accommodate 146 residents, both male and female over the age of 18. The registered provider is the Health Service Executive and is located on the St. Mary's Hospital Campus, Phoenix Park in Dublin. The centre consists of two purpose-built buildings,Teach Iosa (100 beds) and Teach Cara (46 beds). Both buildings have two storeys, and are divided into six units. Residents of all levels of dependency can be accommodated in the centre, and 24 hours nursing care is provided. There are a range of multidisciplinary staff who strive to promote person centred care and aim to implement evidence based quality care for all residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	135

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	07:30hrs to 16:10hrs	Sarah Armstrong	Lead
Tuesday 31 March 2026	07:30hrs to 16:10hrs	Aoife Byrne	Support
Tuesday 31 March 2026	07:30hrs to 16:10hrs	Niamh Moore	Support

What residents told us and what inspectors observed

Overall, inspectors found that residents living in Phoenix Park Community Nursing Units were well cared for and well supported to live a good quality of life by a dedicated team of staff. Residents were complimentary about staff and the care they provided. Inspectors observed numerous kind and courteous interactions between staff and residents throughout the day of inspection. There was a large number of residents who were living with a diagnosis of dementia or cognitive impairment who were unable to verbally express their opinions on the quality of life in the centre, however they appeared to be content and comfortable and staff spoken with expressed a good knowledge of their individual needs.

This was an unannounced inspection completed by three inspectors of social services over the course of one day. The purpose of the inspection was to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the compliance plan received from the previous inspection which was held in September 2025, statutory notifications submitted by the provider, and unsolicited information received about the centre since the last inspection.

On arrival to the centre, the inspectors completed a walkabout of the premises which provided inspectors with an opportunity to introduce themselves to residents and staff. The majority of residents were having their morning care needs attended to by staff, while some were up and about in the communal areas. There was a relaxed and unhurried atmosphere in the centre throughout the day of inspection. Where residents rang their call bells, these were observed to be promptly responded to by staff.

Phoenix Park Community Nursing Units consists of two separate buildings referred to as Teach Iosa and Teach Cara. Teach Cara consisted of two residential units, for a maximum of 46 residents, referred to as Bebhinn and Setanta. The Bebhinn unit is located on the ground floor and contained 17 single bedrooms, two twin bedrooms and one four bedded-room. The Setanta unit is located on the first floor and contained 19 single bedrooms and one twin bedroom. The Teach Iosa building contains four residential units, for a maximum of 100 residents. Oisin and Conall units were located on the ground floor and Tara and Ailbhe units on the first floor. All four units contained 17 single bedrooms, two twin bedrooms and one four bedded-room.

Inspectors observed that some rooms in the designated centre were not appropriately set up for residents, for example, not all communal areas had a call bell facility and there were some examples of damaged furniture and scuffed paintwork noted. At the time of inspection, there was a programme of works ongoing to improve the premises. As part of this, inspectors observed significant ongoing works to replace the flooring on Bebhinn unit in Teach Cara. To

accommodate these works, some residents had moved temporarily to Teach Iosa. Residents who remained on Bebhinn unit during the period of works were impacted by restricted access to communal space as the conservatory was being used as a store room to accommodate the works. Inspectors were told that this arrangement was expected to impact the residents for a further month.

Following the morning walkabout of the premises, an introductory meeting was held with the two persons in charge in the centre, where the purpose of the inspection was set out.

Overall, mealtimes were found to be a positive experience for residents. In the morning, the inspectors observed breakfast set out on food warmers in the dining rooms. Residents had the option of different cereals and hot breakfast options. This approach supported residents to see what food options were on offer, and also to experience the smells associated with breakfast, such as toast and sausages. Inspectors also observed lunch being served to the residents and the food looked hot and nutritious. There was a choice of chicken kiev or cod for lunch. There was only one option of level 5 minced moist diet, minced chicken, available to residents on the day of inspection, however the menu indicated there was two options available. The menu for the evening time meal also only outlined one option for the level 4 pureed diet. For those residents who required assistance, there were plenty of staff available to provide assistance and staff were observed sitting beside residents and assisting in a kind, and unrushed manner. Residents' feedback about the quality and quantity of food provided was overall positive, with residents saying "the food is lovely". Inspectors spoke with one resident who said they preferred to eat their meals in their bedroom. This resident commented "the food is very good, anything you want you can get", this resident also told inspectors that their meals were always hot when they received them to their room. Inspectors observed that one resident did not enjoy their meal choice on the day, however staff responded to this and provided them with an alternative option and the resident told the inspectors they were happy and enjoying the alternative option.

The inspectors spoke with a number of residents on the day of inspection. Residents spoke highly of the staff who supported them. One resident told the inspectors "the staff are great, they're fantastic". When asked about the quality of the service provided to them, one resident said "I am very happy, I've never had any problems since I've been here". Residents were aware of the procedure in place for making complaints and those who spoke with the inspectors said they felt comfortable to communicate any concerns to a member of staff. Residents also told inspectors that they felt safe living in the centre.

A schedule of activities was available in prominent locations throughout the centre. On the day of inspection, residents had access to activities including word games, poetry, proverbs, book club, newspaper reading, walks and one to one activities including manicures. Notice boards also provided information on additional social events and outings scheduled to take place in April, including an Easter concert and Easter bonnet competition, a coffee morning and an outing to an oratory in Blanchardstown followed by lunch in the shopping centre.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

A number of improvements had been made following the previous inspection which was held in September 2025. Action had been taken to improve the oversight of staff practices during residents' meal times to ensure residents were supported to dine with dignity, and increased oversight of the safe storage of medications and daily temperature checks of medication rooms. There was evidence that the management team were conducting regular walkabouts of the premises, and records showed that the management team were identifying issues in the centre and establishing clear action plans to address issues found. Despite these improvements, inspectors found some repeat findings in respect of residents' individual assessment and care plans, managing behaviours that challenge, safe storage of residents' records and the premises. These will be discussed in more detail under the appropriate regulations later in this report.

Inspectors also identified that the registered provider had changed the functions of some rooms within the designated centre, without informing the Chief Inspector of those intended changes, as a result the registered provider was in breach of Condition 1 of their registration. This is further discussed under Registration Regulation 7: Applications by registered providers for the variation or removal of conditions.

The registered provider of Phoenix Park Community Nursing Units is the Health Service Executive. There was a well defined management structure in place with clear lines of responsibility and accountability established. At the time of this inspection, there were a number of staff vacancies in the centre. A mix of agency staff and the centre's own staff were currently filling gaps in rosters. The registered provider was making efforts to secure the same agency staff as much as possible to promote continuity of care and the use of familiar staff in the centre for residents. The registered provider was actively recruiting both staff nurses and health care assistants at the time of inspection and job offers had been accepted by three staff nurses with a start date for these three new staff pending confirmation.

Staff had access to a suite of training appropriate to their roles. From a review of the centre's training matrix, inspectors found high levels of compliance with safeguarding vulnerable adults training, where 97% of staff had up to date training in this area. However, excluding newly appointed staff and staff on long term leave, gaps were identified with other trainings including 31% of eligible staff were not up to date with manual handling training and 20% of staff were not up to date with fire safety training. In addition, 66% of staff were out of date with training in the use of

restraint in accordance with the time frames set out the centre's own policy. There was evidence that training in fire safety and manual handling had been scheduled and staff who were due these trainings were listed to attend. There were some gaps in the number of staff who had completed training on managing behaviours that challenge, however, there was evidence that staff were currently being supported to complete this training on a rolling basis in line with the compliance plan from the previous inspection. The registered provider had set a target for all staff to be up to date in this training by 30 September 2026. These findings are discussed further under Regulation 16: Training and staff development.

Some improvements were noted with regards to the storage of residents' records since the previous inspection, however, practices around this were not consistent across all units of the centre. For example, records were found to be stored securely and safely on Conall and Oisin units, whilst on Ailbhe, Tara, Bebhinn and Setanta units, residents' records were not held safely and were stored in unlocked cabinets at the nurses' stations. In addition, other personal information including residents' names and dietary needs were observed pinned to notice boards in areas accessible by residents and members of the public. This is a repeat finding from the previous inspection and is discussed further under Regulation 21: Records.

Staff were familiar with the policies and procedures in the centre and inspectors observed copies of policies and procedures were physically available to staff on each unit. All policies and procedures had been reviewed and updated within the time frame set out in the regulations. Although the safeguarding and risk management policy were updated following the findings of the last inspection, inspectors found that the policy on risk management required further updating to ensure all information required by the regulations was included. This finding is discussed further under Regulation 23: Governance and management.

Residents were aware of the policy in place for managing complaints and told inspectors that they felt safe and supported to raise any concerns with the staff team. There was evidence that complaints received were managed in line with the centre's policy.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider had not submitted an application to the Chief Inspector in line with Section 52 of the Health Act, to vary a condition of registration attached by the Chief Inspector under Section 51 of the Act. This was evidenced by changes to the function of areas within the centre which were not notified to the Chief Inspector in advance of changes being made. For example;

- The designated purpose of two store rooms on the Tara and Ailbhe units were converted to tea rooms for use by staff.
- The designated purpose of an office in the Setanta unit was converted into a day room for use by residents.

- The designated purpose of a linen room in the Setanta unit was converted into an office.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were aware of the Health Act 2007 and Regulations made under it. Staff had access to appropriate training relevant to their roles. Gaps in some trainings were being addressed by upcoming scheduled sessions for staff. However, 90 staff members were not up to date with training in the use of restraints in line with the time-frame set out in the centre's own policy, and there was no evidence presented to inspectors that training was scheduled to address the gaps in this area. Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. For example:

- There were examples identified where residents were receiving care which was not aligned to their care plan or assessed needs. For example, one resident was being placed in continence products despite being assessed as being continent.
- Safeguarding care plans in place were not being followed by all staff. For example, on the day of the inspection there were gaps in records of supervision and safety checks for a resident who required monitoring every 30 minutes. Inspectors were told this was due to high levels of agency staff use.
- Residents records with personal information being stored unsecured at nurses stations and visible on notice boards.
- Inappropriate storage, including boxes of continence wear, wheelchairs and a mattress in assisted bathrooms.

Judgment: Substantially compliant

Regulation 21: Records

Residents records were not always kept in a manner which was safe. This was evidenced by the following findings;

- Residents' care plans were being held in unlocked cabinets at some nurses stations.
- Residents' information, including dietary needs, was displayed on notice boards at some nurses stations and in the dining room in the Bebhinn unit.

- On Bebhinn unit, records displaying residents' personal information were being stored in an assisted bathroom.

This is a repeat finding.

Judgment: Not compliant

Regulation 23: Governance and management

Further improvements were required to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example;

- The registered provider did not submit an application to the Chief Inspector to inform of proposed changes to the function of five areas of the designated centre as set out under Registration Regulation 7.
- Insufficient oversight of the implementation of the compliance plan from the previous inspection to ensure that resident areas were fitted with call bell facilities, residents' records were stored securely and updates required to policies and procedures were fully implemented to ensure the risk management policy included all risks outlined under Regulation 26(1)(c).
- Insufficient oversight of documentation to ensure that care plans and assessments were updated and accurate to enable staff to deliver care appropriately.
- Insufficient oversight of staff practices to ensure appropriate storage practices in the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had in place an accessible and effective procedure for dealing with complaints. Inspectors reviewed a sample of complaints and found these were managed in line with the centre's own policy.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing, all policies and procedures as set out under Schedule 5 of the regulations. Policies and procedures were made available to staff.

Judgment: Compliant

Quality and safety

In general, residents living in Phoenix Park Community Nursing Units received a good standard of care from a caring and dedicated staff team. Residents had good access to health care professionals including medical practitioners, physiotherapists, and tissue viability nurses. Where required, residents also had access to out of hours medical support. However, a number of areas fundamental to a high quality service such as care planning, the management of responsive behaviours and the premises required action to meet the requirements of the regulations in these areas.

Inspectors reviewed a sample of care records in each of the six units. The centre had a paper-based record system and inspectors found there was a variation in the degree of personalisation of care plans. While inspectors found that regulatory time frames for completing an assessment and developing a care plan for a resident following admission to the centre had been met, not all care plans reviewed sufficiently guided care. For example, some care plans were not developed based on assessments, and some were not individualised to residents' assessed needs and preferences. This was particularly relevant due to the high number of agency staff that may not know residents usual routines and preference. This is further outlined under Regulation 5: Individual assessment and care plan.

There was a policy in place to guide staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors saw evidence that the provider had training dates planned to ensure all staff had the knowledge and skills for managing behaviour that challenges. However, inspectors found that in a review of records and care plans, incidents were not always managed using the de-escalation techniques outlined in the resident's care plan. This and other gaps are further discussed under Regulation 7: Managing behaviour that is challenging.

There were arrangements in place to safeguard residents from abuse. Staff had received training in the safeguarding of vulnerable adults, and the registered provider had a safeguarding policy. Inspectors saw that referrals were submitted to appropriate external agencies, for example the safeguarding and protection team. Residents reported feeling safe within the centre.

The inspectors followed up on the compliance plan in respect of medicines and pharmaceutical services. Inspectors found that the person in charge had completed

all actions committed to in the compliance plan from the previous inspection. Medications were found to be stored safely on the day of inspection, and there was a process in place for checking the temperature of medication rooms and fridges. These records were completed as required, with no gaps, and temperatures were found to be within the expected range.

Residents who spoke with inspectors were knowledgeable of the activities scheduled in the centre. Some residents chose to participate in group activities and outings, whilst other residents told inspectors that they preferred to opt out of them. Residents also said that staff respected their choices when it came to the care they received. Residents had access to newspapers, televisions and radios in the centre and were supported to access independent advocacy services. Inspectors reviewed a sample of residents' meeting minutes and found that residents were provided with opportunities to be involved in the organisation of the designated centre.

Improvements were required in respect of the premises to ensure compliance with the regulations. Inspectors identified areas used by residents which were not equipped with emergency call bell facilities. This was also a finding on the previous two inspections. In addition, some areas of paintwork were scuffed and some furniture was damaged or torn in both buildings. Inspectors also observed inappropriate storage in assisted bathrooms in the centre. These findings are discussed further under Regulation 17: Premises.

Regulation 17: Premises

The premises did not conform to all matters as set out under Schedule 6 of the regulations. This was evidenced by the following findings;

- Not all areas for use by residents were equipped with call bell facilities or had call bells accessible to residents to call for assistance. This is a repeat finding. For example;
    - The conservatories on each unit in the Teach Iosa building, the multi-purpose room in the Setanta unit, the day room on the Setanta unit and a toilet on Ailbhe unit did not have call bell facilities. The pull cord for the call bell was missing from the assisted bathroom on Ailbhe unit.
    - The pull cord for the call bell in the assisted bathroom on Tara unit was not accessible to residents, as it was blocked by a shower trolley.
    - The call bells in assisted bathrooms were not accessible to residents from the toilet in these areas.
- Furniture in the conservatory in Tara unit was torn, and there was a damaged couch in the day room in the Setanta unit.
- There was damage to paintwork along corridors in the Bebhinn unit and in the dining room in Setanta unit.
- There was ineffective ventilation in all sluice rooms which was resulting in a malodour being present.

- Urine bottles were stored in the sluice rooms which were found to be visibly unclean and had a build up of sediment and staining present.
- There was inappropriate storage observed in a number of areas. For example, assisted bathrooms were being used to store items such as incontinence wear, mattresses and wheelchairs.
- Maintenance cupboards, although lockable, were all found to be unlocked. These cupboards housed electrical panels and in some cases, the metal cover had not been replaced on the panels meaning electrical wires were easily accessible to residents.
- On corridor sub distribution boards were not always locked despite signage in place stating "fire door keep locked". For example, on Oisin unit, the sub distribution board was unlocked and there was inappropriate storage of cardboard boxes in this cupboard. This presented a fire hazard.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors followed up on the compliance plan from the previous inspection and found that the provider had put in place all actions committed to as part of their compliance plan. Temperature checks were in place for medication rooms and medication fridges. There was evidence that temperature checks were conducted daily, with no gaps and all temperatures recorded were within the appropriate temperature range. Medications were stored securely in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Following a review of a sample of comprehensive assessments and care plans, not all care plans reflected the current assessed needs of residents, and were not consistently person-centred, with insufficient detail to support staff in providing appropriate care. For example:

- A comprehensive assessment identified that one resident was continent. However on discussion with staff the resident was wearing continence products, without a continence assessment completed.
- An elimination care plan indicated that one resident was continent, however the resident wore continence products. Additionally, the continence assessment indicated the resident was at risk of developing incontinence due to dementia but had no other continence concerns.

- A skin integrity care plan did not include important details which were identified in a comprehensive assessment, such as the resident requiring four hourly repositioning, an air mattress and a high risk waterlow score.
- Two safeguarding care plans referred to generic or organisational safeguarding measures and were not person-centred, and did not identify specific actions staff needed to take to safeguard the resident.

This is a repeat finding.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

There were gaps in documentation that did not provide assurance that staff consistently implemented local policy and managed behaviours that challenge to align with the interventions outlined in the resident's individualised care plans. For example:

- A review of documentation including care plans and behaviour charts for residents identified as displaying behaviours that challenge, found that alternative interventions and de-escalation techniques were not fully outlined to direct the care of the resident.
- Two exit seeking care plans were not reviewed following a change in a resident's condition. For example, one resident was wheelchair bound and unable to exit without the assistance of staff and another resident no longer displayed exit seeking behaviour.
- On one occasion, a resident had been administered psychotropic medication used in the treatment of anxiety, however, there was no documented evidence that the resident displayed behaviour that challenged prior to administration or sufficient documentation of the rationale for its use.
- One-to-one staffing was put in place in response to an incident of peer-to-peer physical abuse, however there was no care plan or assessment in place to identify the rationale for this or to guide staff on how to manage and respond to the behaviours.

Further review of all restrictive practices were required to ensure the least restrictive measure was in place in line with National Policy Towards a Restraint Free Environment in Nursing Homes. For example:

- Inspectors reviewed a sample of behavioural records for one resident who had one-to-one staffing in place, a number of incidents had occurred where medication was given without prior trialling of the de-escalation therapeutic techniques outlined within the resident's care plan.
- A resident had a secure bracelet implemented in November 2024 due to an identified risk of absconsion. However, this restrictive practice remained in

place despite an assessment completed in October 2025 outlining no further risks were present.
- A resident's risk assessment and care plan directed staff to remove a resident from communal areas at specific times, however, increased supervision was in place and there was insufficient information as to why this additional restriction was required. This is a repeat finding from the last inspection.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had taken reasonable measures to ensure that residents were protected from abuse. These measures included staff training in relation to the detection and prevention of, and responses to abuse, of which there were high compliance rates noted. The person in charge had investigated incidents and allegations of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors followed up on the compliance plan from the previous inspection and found that the provider had put in place all actions committed to as part of their compliance plan.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Phoenix Park Community Nursing Units OSV-0000476

Inspection ID: MON-0050083

Date of inspection: 31/03/2026

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**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: • Application for varying use of rooms will be submitted to the Chief Inspector.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Ward CNMs' will ensure all Continence assessments are up to date and adhered to by their staff by 14th June 2026 • Ward CNMs will ensure safety checks are completed and documented at appropriate times throughout the day by all staff, including agency staff • Filing cabinets containing residents' care plans are locked and keys held by the nurse responsible for those residents' care by 15th May 2026 • Ward CNMs will ensure there is no over ordering of stock and stock is stored appropriately • Ward CNMs will ensure any surplus equipment is removed to storage once it is no longer in use, i.e. mattresses by 29th May 2026	

• In-house Restraint/Restrictive devices training will commence by 31st May 2026

Regulation 21: Records	Not Compliant

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

• Filing cabinets containing residents' care plans are locked and keys held by the nurse responsible for those residents' care by 15th May 2026
• Information pertaining to residents' dietary requirements will be removed from public spaces by 15th May 2026. This information will be kept in the ward pantry for relevant staff to access
• Residents' files have been removed from assisted bathroom in Bebhinn Ward and stored appropriately

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Application to vary use of rooms will be submitted to the Chief Inspector by COB on Friday June 5th 2026. Rooms will be returned to their proper use or will be re-designated on floor plans.
• Risk management Policy has been updated to include risk of Infectious diseases.
• List of call bells required have been submitted to St Mary's Hospital Operations Department and work will commence on June 02nd 2026 and will be completed by June 9th 2026.
• A care plan documentation group has been convened to have better oversight of care plans. Two nurses from each ward are participating in this group and will be the liaison between the group and other staff on the ward offering assistance when required
• Activity of Daily Living forms will be completed yearly rather than three yearly and care plans will continue to be updated quarterly or sooner if the residents' condition changes
• All care plans will be reviewed and updated by 30th June 2026
• Ward CNMs will ensure there is no overordering of stock and stock is stored appropriately
• Clutter will be removed from wards by 1st June 2026

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• List of call bells required have been submitted to St Mary's Hospital Operations Department and work will commence on June 02nd 2026 and will be completed by June 9th 2026.
• Furniture in need of repair has been identified and sent for re-upholstery.
• A new couch has been delivered to Setanta Ward
• Damaged paintwork in Bebhinn Ward will be repaired by 30th August 2026 once the floor works are completed
• The wall in Setanta Ward's Day Room has been repainted
• ADON has requested St Mary's Hospital Operations Department to assess the ventilation system in sluice rooms to ensure it is working properly
• Staff on all wards have been instructed to discard any stained urinal bottles and order new urinals as required.
• Ward CNMs will ensure there is no overordering of stock and stock is stored appropriately
• Clutter will be removed from wards by 1st June 2026
• Maintenance panels have been reported to St Mary's Hospital Operations Department and work will be completed by 31st May 2026
• The sub-distribution boards have been locked since 1st May 2026

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• Ward CNMs' will ensure all Continence assessments are up to date and adhered to by their staff by 14th June 2026
• Continence education sessions will be rolled out for all staff at ward level
• Ward CNMs with the assistance of the documentation group will ensure all safe-guarding care plans are person-centred and appropriate to the resident by 15th May 2026

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• Ward CNMs will ensure all residents with challenging behaviours will have an updated person-centred care plan to identify specific needs and interventions by 14th May 2026
• Following an episode of challenging behaviour, documentation will outline all interventions trialed prior to administration of any medication
• Exit-seeking care plans will be reassessed to ensure they reflect the current status of the resident by 1st June 2026
• Rationale for commencing 1:1 companion care will be clearly documented and all interventions recorded for the companion carer to follow by 15th May 2026

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
Registration Regulation 7 (1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition or conditions of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	05/06/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	14/06/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	29/05/2026
Regulation 17(2)	The registered provider shall, having regard to	Not Compliant	Orange	30/06/2026

	the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	15/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	09/06/2026
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).	Not Compliant	Orange	14/06/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Not Compliant	Orange	15/05/2026

	the resident concerned and where appropriate that resident's family.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	01/06/2026
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.	Not Compliant	Orange	15/05/2026