



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Baltinglass Community Hospital
Name of provider:	Baltinglass Community Hospital
Address of centre:	Newtownsaunders, Baltinglass, Wicklow
Type of inspection:	Unannounced
Date of inspection:	24 June 2025
Centre ID:	OSV-0000485
Fieldwork ID:	MON-0047083

About the designated centre

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

The centre caters for a maximum of 54 residents and provides care to both male and female residents over 65 years of age. The centre provides 54 residential beds; 11 of these beds (including one respite bed) are specifically dedicated to dementia care and will accept residents under 65 years of age with a diagnosis of dementia. There are two respite beds in total in the centre. Accommodation is divided into three units. Ceidin unit accommodates 25 residents in twin and single bedrooms providing a mix of en suite and communal wheelchair accessible toilet, shower and bathing facilities. There is a large communal lounge and dining room and two smaller seating areas. Primrose unit is a specialist 12 bed unit which provides accommodation for residents with a diagnosis of dementia. The unit comprises seven bedrooms providing single and twin bedroom accommodation, one with en suite and communal toilet and bathroom facilities. There is a communal lounge/dining room which leads out to the enclosed dementia friendly garden area and an additional smaller communal room. Willow unit accommodates 18 residents in single and twin bedrooms with a mix of en suite and communal wheelchair accessible bathrooms and toilets. There is a large communal lounge/dining room a small chapel and smaller seating areas leading out to the garden and gazebo. The centre has recently extended the entrance area to provide a pleasant cafe and meeting area which welcomes residents and their visitors.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	42
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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 24 June 2025	08:05hrs to 17:45hrs	Aoife Byrne	Lead
Thursday 26 June 2025	17:55hrs to 21:30hrs	Aoife Byrne	Lead
Tuesday 24 June 2025	08:05hrs to 17:45hrs	Niamh Moore	Support
Thursday 26 June 2025	17:55hrs to 21:30hrs	Niamh Moore	Support

What residents told us and what inspectors observed

Inspectors found that residents living in this centre were well cared for and well supported to live a good quality of life by a dedicated team of staff that knew them well. Residents were complimentary about staff and the care they provided. One resident told inspectors that "I am happy with everything here" while another said "the staff are so good and friendly". Residents spoken with were happy with staffing levels except one resident who said there is not enough staff stating that the staff are very tired and over worked. Overall residents and family members spoke highly of the care, bedrooms, food and activities on offer.

This unannounced inspection was carried out over two days. The first day of the inspection commenced in the morning at 08:05hrs to 17:45 hrs. The second day occurred two days later at 17:55hrs to 21:30hrs. The observations from each day showed areas of good care. On arrival, inspectors were greeted by the assistant director of nursing (ADON). The person in charge (PIC) was not present in the centre due to annual leave but did arrive later in the morning to facilitate the inspection. Inspectors spent time walking through the centre before the introductory meeting, which provided inspectors an opportunity to introduce themselves to residents and staff. Some residents were observed to be up and about while others were having their morning care needs attended to by staff.

Baltinglass Community Unit is located on the outskirts of Baltinglass, County Wicklow and is registered to provide care for 54 residents, however due to planned refurbishment, the centre was accommodating a maximum of 46 residents. On the day of this inspection there were 42 residents living in the centre. The centre was divided into three units named Primrose, Ceidin and Willow Way which was subdivided into Willow Way West and Willow Way East. There was a programme of refurbishment works due to commence in the centre, with the first phase on Primrose unit. This unit is a dementia-specific unit and was closed to residents for the duration of the refurbishment and all the residents had been moved to Willow Way West unit. To facilitate the sub-division of the unit to support residents with dementia, a pin-coded door was installed. Inspectors found that when this door was opened or closed it also had an alarm which sounded loudly. Inspectors queried the reason for this alarm in addition to the pin-coded door, staff told inspectors this was due to absconsion risks, however there was no risk assessment available. Staff told inspectors that they found the noise from this alarm disturbing.

On the first day of inspection inspectors observed a substantial amount of flies in the centre, including in the residents bedrooms, communal spaces and offices. Windows were open due to the warm weather. Inspectors were told that this was due to the surrounding farmland, however another staff member said it was not usual to have flies within the centre. While some measures had been taken these were insufficient and at times inspectors and staff were swatting flies which were observed to land on residents. Management contacted pest control after inspectors discussed the issue regarding the flies. One resident spoken with stated they were "

sick of the flies” and another said “ they need to put things in place to remove the flies”. On the second day of inspection it was observed there were less flies in the centre and that steps had been taken to address the issue to include maintenance staff and pest control attending on-site. Inspectors were also told by a resident "the flies are much better today".

Residents’ bedrooms were personalised and homely. A large number of bedrooms were multi-occupancy. A resident complained in relation to the lack of privacy in their shared bedroom, saying the privacy screens were not always used appropriately. While the glass panels on some bedroom doors were covered with an opaque film, it was noted that four bedrooms continued to have no film or limited film in place to provide appropriate privacy and dignity to the residents in these rooms.

When inspectors arrived for day two of the evening inspection, they observed that the atmosphere in the centre was relaxed and calm. While there were adequate numbers of staff, it was observed on two occasions there were seven residents in Willow Way West communal area and no staff were present to provide supervision. One staff member was observed to be attending to a call bell while another staff member was returning from break, it was unclear how long the communal space was unsupervised for.

On day one, the inspectors observed the lunch-time experience. Menus were displayed on boards within the dining rooms. There were choices available of beef stew or grilled hake, and the food served appeared appetising and hot. There was sufficient staff available to provide support where necessary, and those assisting residents did so in a respectful manner. Snacks and drinks were seen to be offered to residents throughout the day.

Inspectors observed numerous kind and caring interactions among staff and residents throughout the two days. There was one to one as well as group activities available throughout the day. Inspectors found that residents had opportunities to engage in meaningful engagement led by dedicated activity staff in line with their choices and preferences. Residents were seen to be supported to join activities in communal areas, such as mass, board games and music. There were daily newspapers available and inspectors observed staff assisting residents to receive these in their bedrooms. Some residents were seen to be supported with one-to-one sessions, including discussions from daily newspapers. The community Gardai also attended the centre on day one of this inspection, and staff told inspectors that they are routinely informed of residents' meeting dates.

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

Capacity and capability

Overall, the residents were supported and facilitated to have a good quality of life living at the centre. A management structure was in place and the registered provider had systems to support the provision of a good standard of evidence-based care. Some improvements had been made since the last inspection in January 2025 such as an introduction to safeguarding processes. Notwithstanding the management systems in place, some further action was required to ensure all management systems were effective and proactive at identifying areas for improvement. Other findings on the day showed that action was required in managing behaviours that challenge, protection, residents rights, records and training. This will be discussed later in the report.

This unannounced inspection focused on adult safeguarding and to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended) and to ensure the residents were safe and receiving an appropriate standard of quality care. The inspectors followed up on unsolicited information received in respect of staffing, safeguarding, supervision and governance and many of the concerns were substantiated.

The Health Services Executive (HSE) is the registered provider of Baltinglass Community Unit. The PIC is responsible for the centre's day-to-day operations and reports to the general manager for older person services. The general manager is the person delegated by the provider with responsibility for senior management oversight of the service. The PIC was supported in their role by an ADON, six clinical nurse managers (CNM), three were grade two and three were grade one, staff nurses, health care assistants, activity staff, and household staff. The designated centre was also supported by clerical officers, porters, medical officers and allied health professionals.

Regular clinical governance meetings and staff meetings were occurring, however it was not evident that actions were being implemented. The registered provider had audit and monitoring systems in place to oversee the service. However, the audit system was not sufficiently robust in all areas, this is discussed further under Regulation 23: Governance and Management. Inspectors found that the person in charge did not have full knowledge and overview of the designated centre as each unit worked independently where the CNMs were responsible for oversight of their individual units, which did not ensure consistent practice throughout the centre. For example, inspectors found that the use of the safeguarding toolkit and audits carried out on responsive behaviours was inconsistent across the three units.

Staff had access to a programme of training that was appropriate to the service, yet gaps were seen in relation to the compliance of staff training. Following the compliance plan from the last inspection the designated centre identified that a human rights based approach to care was important and planned for all staff to

complete human rights training, however, by the time of this inspection, it was completed by 25% of staff. The management team completed safeguarding training and there was a total of eight designated safeguarding officers. Inspectors were informed that the plan going forward was to train all management to ensure there is a designated safeguarding officer available on each shift. Inspectors were informed on the day of inspection that face to face safeguarding training was postponed due to an outbreak of COVID19 in the centre in June 2025.

Staff files and residents records were maintained in the centre in a secure but easily accessible format. Other records, required to be maintained in the centre were in place, for example, records of medication administration and a record of all incidents occurring in the centre was maintained. However, some records required under Schedule 2 and requested as part of this inspection were not available and this is discussed under Regulation 21: Records.

Regulation 16: Training and staff development

Following up on the compliance plan, there was no change in the levels of staff trained in safeguarding since the last inspection. The planned date for all staff to have completed updated training was May 2025. This is a repeat finding.

Judgment: Substantially compliant

Regulation 21: Records

The record management system in place did not ensure that records were maintained in line with the regulations. A small number of staff files did not contain the requirements set out in Schedule 2 of the regulations. For example;

- Two staff files did not contain records of disciplinary action, records in relation to an investigation and supervision of staff following an incident. Therefore inspectors could not be assured that the appropriate action had been taken.
- One staff file did not contain records of their employment to include their probation review.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were oversight arrangements in place for the centre, some areas of the service required more targeted management. For example;

- Oversight of documentation did not identify the following;
- There were inconsistencies in the implementation of the daily audit of Antecent, Behaviour and Consequence (ABC) logs carried out by management. For example, in one unit this log was completed when there was no recorded incident and on one occasion, while an incident occurred this was not identified or documented.
- Inspectors were informed that two staff members were receiving increased supervision, however this was not documented in their staff files.
- Systems in place to recognise and respond to safeguarding concerns were not effective. For example, two safeguarding concerns had been recorded in residents meetings and were not recognised by management as potential safeguarding concerns. As a result, there were no assurance that these incidents were investigated with appropriate safeguarding plans put in place to protect residents' from the risk of abuse.
- It was evident that management were having regular meetings, however the application of actions and learnings identified were not always completed.
- Oversight systems to ensure the submission of notifications to the Chief Inspector were not effective.
- The registered provider had not ensured that actions submitted as part of the compliance plan from the previous inspection had been completed within the allocated time frame. For example, repeat findings were found in relation to regulations as outlined within this report.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors found three notifiable incidents that had occurred in the centre. However, these were not notified to the Chief Inspector of Social Services as set out in Schedule 4 of the regulations. Inspectors requested these incidents to be notified, as required. The person in charge submitted the notifications following the inspection. This is a repeat finding since the last inspection.

Judgment: Not compliant

Quality and safety

Overall residents appeared happy living in the centre. Inspectors found that staff were familiar with and were responsive to residents' needs. However, action was required to ensure a safe and good quality service for all residents, particularly in the areas of responsive behaviour, restraints, safeguarding and residents' rights.

A sample of care plans were reviewed on the day of inspection. Validated assessment tools supported the assessment of residents to establish if residents were at risk of falls, malnutrition or impaired skin integrity and where required, these were seen to be completed at a minimum of every four months. Inspectors saw care plans were updated at four monthly intervals in line with the regulations. Some good examples were seen relating to clear guidance of a residents dietary requirements, including updated instructions from the dietitian. However, there were examples seen that did not have sufficient information to guide staff practice, this is further discussed under Regulation 5: Individual assessments and care plans.

There was a policy on responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) available for staff. Residents predisposed to episodes of responsive behaviours had a responsive behaviour care plan and other documentation to guide staff. However, inspectors found evidence where the de-escalation measures in place for one resident had not been fully trialled, and the management plan for the resident was restrictive.

There was evidence that when restraint such as bed rails were used, an assessment and a care plan was completed to ensure it was the least restrictive measure in place. However, inspectors found gaps in this oversight for all other types of restraint, this is further discussed under Regulation 7: Managing behaviour that is challenging.

Residents had access to television, radio, newspapers and books. Residents were supported to access advocacy services and information about their rights was available on notice boards in the centre. Residents had opportunities to attend residents' meeting and they were updated on key aspects of the service such as activities, health care, equipment and safeguarding. Residents had meaningful engagement care plans and there was key information available in documentation to include their interests and memorable dates for residents such as birthdays and wedding anniversaries. Notwithstanding these good findings, improvement was required to ensure residents' rights to privacy and consultation were upheld. This is further outlined under Regulation 9: Residents' rights.

An updated safeguarding policy was in place. Staff spoken with were knowledgeable regarding what may constitute as abuse and the appropriate actions to take, should there be an allegation of abuse made. Prior to commencing employment in the centre, all staff were subject to Garda vetting. Each unit had implemented the use of the safeguarding toolkit which occurred weekly with staff. A safety pause and staff "huddle" occurred daily where safeguarding and any relevant issues arising on the units were discussed.

There was a policy available to guide staff on resident communication effective from January 2023. Communication requirements were seen to be recorded in assessments and these informed the development of communication care plans.

Regulation 10: Communication difficulties

Residents with communication difficulties had access to specialist services such as GP, speech and language therapy, ophthalmology and audiology as required. Staff spoken with outlined their awareness of any specialist needs to enable residents to communicate freely including non-verbal cues and appropriate interventions such as communication books to support residents.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Improvements were required in respect of residents care plans to ensure that care plans were person-centred, reflected the current needs of residents, and included information which was sufficiently detailed to guide staff in providing good quality care. For example;

- A resident's behaviour care plan outlined some of the potential triggers of their behaviour. However, inspectors saw that there was no behavioural support plan actioned to de-escalate and reassure the resident.
- Inspectors saw one care plan which described restrictive measures to manage the resident's responsive behaviour .
- Where a resident did have a safeguarding plan in place, it did not adequately describe the residents care needs and personal preferences in a detailed and person-centred manner required to guide staff to deliver effective, person-centred care. For example, the same safeguarding template plan was used for several residents.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

While staff had access to training in areas such as dementia care and de-escalation training, inspectors saw that staff had not demonstrated up-to-date knowledge and skills to manage and respond to responsive behaviour. This is further discussed under Regulation 5: Individual assessment and care planning.

Restraint use was not in line with the registered provider's own policy on Restrictive Practice and the *National Policy Towards a Restraint Free Environment in Nursing Homes*, for example:

- The assessment forms in use for sensor alarms and low low beds did not evidence the alternatives trailed to ensure the least restrictive measure was in place for the least time required.
- There was an alarm and coded doors into the dementia specific unit. There were no risk assessments completed for residents which identified the requirement of both the alarm and locked doors.

Judgment: Not compliant

Regulation 8: Protection

Two concerns from residents had been recorded in residents meetings and were not recognised as potential safeguarding concerns. For example, a resident reported money going missing and this was not recognised as potential financial abuse while another resident reported a concern around neglect and staffs response to personal care. The management systems in place had failed to identify these and no investigation or safeguarding plans were put in place to protect residents'.

Following the last inspection in January 2025 senior management arranged an independent review of safeguarding practices in February 2025. The actions and recommendations to enhance safeguarding compliance, improve residents experience and support staff were not fully implemented by management however some actions were underway.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' views on the organisation of the centre were sought but there was no evidence that all feedback was actioned. For example, inspectors saw within residents' meetings of April 2025 where a resident raised a concern regarding food and there was no action plan put in place. In addition, concerns relating to staff responding to residents' personal care requested were repeated in minutes of March 2025 and April 2025 meetings with no action plan to respond to this feedback.

The providers' oversight with regard to respecting residents' privacy in bedrooms required further action. For example:

- While some windows into bedrooms had sufficient film to prevent those passing on the corridors the view into these rooms, many bedrooms did not have sufficient amounts of film to cover the full window. In addition, some bedrooms did not have any film on the windows.
- While some privacy screens were seen to be available in multi-occupancy bedrooms, many of these screens were not in use throughout the inspection.

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 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Baltinglass Community Hospital OSV-0000485

Inspection ID: MON-0047083

Date of inspection: 26/06/2025

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Person in Charge to review and amend the governance oversight of the designated centre training tracker ensuring accountability of staff compliance for training at individual CNMII ward manager level with particular focus on safeguarding and fire safety training– Completed 31/09/25	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • Registered Provider representative arranged for an independent review of the centre's record management system relating to staff files, with an action plan generated to address identified deficits to ensure compliance set out in Schedule 2 of the regulations – Completed 31/09/25	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

- Registered Provider representative arranged for an independent review of the governance oversight of the designated centre's documentation, with a service improvement plan generated to address identified deficits in the following areas – Completed 31/09/25
 - a. Inconsistencies in the implementation of the daily audit of Antecent, Behaviour and Consequence (ABC) logs carried out by management.
 - b. Staff file records to ensure compliance set out in Schedule 2 of the regulations.
 - c. Systems in place to recognise and respond to safeguarding concerns were identified on day of inspection not effective.
 - d. Oversight systems to ensure timely submission of notifications to the Chief Inspector.
- Registered provider to introduce a traffic light dashboard performance tracker system to support the timely delivery of regulatory compliance plan actions. Key objective is to achieve timely tracking of compliance action to address repeated non-compliance findings – Completed 31/09/25 ongoing thereafter.

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

- Person in Charge to include HIQA Notification of incidents requirement as an agenda line item on the monthly CNMII meeting for discussion to increase awareness amongst management staff of ensuring timely notifications to the Chief Inspector of Social Services as set out in Schedule 4 of the regulations. Complete 11/08/25 and ongoing thereafter
- Where incident occurred they are review for learnings at CNMII meetings Complete 11/08/25 and ongoing thereafter

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

- In-House Care Plan training to be delivered to all registered nurses supporting residents' care planning in the designated centre – Complete 31/08/25
- Nurse management team to review residents care plans and generate a targeted improvement plan in respect of deficits identified on day of inspection residents care plans identified on day of inspection – Complete 31/12/25
- CNMII Night management to complete monthly care planning audits in respect of completion of identified target actions for specific residents charts to address the deficits on day of inspection – Complete by 31/12/25 and monthly thereafter

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: • Designated Centre's Multidisciplinary Team to review and update current restrictive practice tool usage in line with the registered provider's own policy on Restrictive Practice and the National Policy Towards a Restraint Free Environment in Nursing Homes. Key areas for consideration alternatives practices to ensure the least restrictive measures are in place for the least time required – Complete 31/08/25 • CNMII nurse manager for the dementia specific unit to generate a risk assessment for residents identified with the requirement for both the alarm and locked door system – Complete 31/08/25	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • Person In Charge retrospectively completed the relevant regulatory notification to the Chief Inspector of Social Services as set out in Schedule 4 of the regulation for two concerns identified on day inspection – Completed 24/06/25 • CNMII nurse manager completed a review on the two safeguarding concerns identified on day of inspection with notification and safeguarding plan generated and submitted to the Community Safeguarding Team - Completed 24/06/25 • Person In Charge to include HIQA Notifications of incidents as an agenda line item on the monthly CNMII meeting for discussion to increase awareness amongst management staff of ensuring timely notifications to the Chief Inspector of Social Services as set out in Schedule 4 of the regulations. In addition where incident occurred they are review for learnings at CNMII meetings – Completed 11/08/25 and ongoing thereafter • The deliver of a timebound safeguarding action plan to enhance compliance with the independent review of the safeguarding practices (February 2025) for the designated centre – Completed 31/01/26	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights:	

- Person In Charge reviewed governance oversight for resident committee meetings and revised the feedback documentation with the inclusion of an action plan section to ensure timely responds to resident concerns – Complete 31/08/25
- All bedroom windows reviewed to ensure adequate amounts of privacy film to cover the full window respecting residents' privacy. The CNMII service walkaround checklists to include a review the status of privacy film on the windows - Completed 31/08/25 and ongoing thereafter

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2025
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	30/09/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
Regulation 23(2)	The registered provider shall ensure that	Not Compliant	Orange	30/09/2025

	effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	11/08/2025
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	31/12/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	31/08/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only	Not Compliant	Orange	31/08/2025

	used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	24/06/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	24/06/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	31/01/2026
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	31/08/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/08/2025

