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:	Virginia Community Health Centre
Name of provider:	Health Service Executive
Address of centre:	Dublin Road, Virginia, Cavan
Type of inspection:	Unannounced
Date of inspection:	05 February 2026
Centre ID:	OSV-0000503
Fieldwork ID:	MON-0045648

About the designated centre

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

The designated centre provides 24-hour nursing care to 56 male and female residents who require long-term and short-term care (assessment, rehabilitation convalescence and respite). The centre is a two-storey extended building located on a greenfield site. The philosophy of care is to provide a caring environment that promotes health, independence, dignity and choice. The person-centred approach involves multidisciplinary teamwork, which aims to embrace positive ageing.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

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
Thursday 5 February 2026	09:00hrs to 16:45hrs	Michael Dunne	Lead
Thursday 5 February 2026	09:00hrs to 16:45hrs	Celine Neary	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors observed that residents were supported by a team of staff who were caring and kind. The inspectors spoke with a number of residents throughout the day, and those who shared an opinion told inspectors that they were happy with the care and support they received. The inspectors observed that residents were comfortable, relaxed, and chatting to each other as they passed the time in the various communal areas. Residents were well-groomed, and appropriately dressed. All residents who expressed an opinion said that they felt safe, and secure living in the centre.

Upon arrival, the inspectors were met by the person in charge, and the inspectors informed the person in charge that they would carry out a walk around of the centre in the first instance, and upon completion would meet with the person in charge to discuss the format of the inspection.

During the walk around of the ground, and first floors, the inspectors saw that staff were attending to residents' personal care needs, and observed that a few residents were up, and ready for the day's routines. On Ilankirka unit there were nine residents still in bed at 10.30am, and when inspectors revisited this unit at 12:30pm there were six residents in their beds. At the time of this inspection, there were 41 residents living in the centre, with 75% of those having a maximum or high dependency assessed need.

Staff interacted with residents in a kind, and compassionate manner. It was evident that staff knew residents well, and were familiar with their care, and support needs. However, residents' feedback to the inspectors was that they were not always able to identify individual staff members such as nurse, or carer if they required help as they were all wearing their own clothes.

Inspectors observed one resident with exit-seeking behaviours walking around the centre unsupervised. Staff did not always engage with this resident or provide support, or re-direction. Inspectors raised their concerns regarding the lack of supervision at the front door entrance into the centre. Visitors or residents could leave the centre by pressing an exit button to release the door. This risk was highlighted to the person in charge, and the person participating in management on the day. Inspectors noted that this door had been secured by the provider.

Fire safety personnel were in attendance on the day, and inspectors observed that works were underway in two bedrooms. These rooms were found unlocked on multiple occasions, and contained sharp objects, and building materials which posed a risk to residents, if they entered into these rooms. Inspectors issued an immediate action to the management team in the centre on the day to have these doors

locked, to safeguard residents from entering these rooms while building works were underway.

The centre is located in a two-story building which comprises, the 29-bedded Illankirka unit on the ground floor, and the 27-bedded Illangrove unit on the first floor, with each unit divided into two separate wings. The first floor was accessible via wheelchair-accessible ramps, and a passenger lift. This centre comprises of a large footprint with three communal facilities available on both the ground, and first floors. Inspectors found that there were insufficient staff numbers available to supervise these facilities when they were used by the residents. On one occasion, inspectors had to inform staff that residents needed assistance, as at the time there was no staff in place to supervise this area.

Inspectors observed that there was a weekly schedule of activities available for residents. Residents were observed taking part in a foot spa activity on the Illankirka unit during the morning, and a group ball game activity in the foyer in the afternoon. There were a number of unplanned staff absences identified on the day of the inspection which impacted on the consistency of care, and support delivery. Observations confirmed that activities coordinators were often interrupted to provide care support to residents, which impacted on their ability to provide a structured social care programme.

On the day of the inspection, residents were provided with a choice of lunch options, which consisted of poached salmon or a loin of bacon. There was a choice of hot, or cold options for the evening meal. If a resident preferred to eat in their room or was unable to come to the dining room, this was facilitated by staff. Food was observed to be well-presented; however, inspectors observed that the food served was lukewarm, and in one of the dining rooms, there were insufficient numbers of staff available to ensure that residents had sufficient support with their food, and drink requirements.

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.

Capacity and capability

Overall, the centre was being managed for the benefit of the residents. The inspectors found that the provider had made progress in achieving compliance with medication management, and had recruited all vacant clinical nurse manager positions. Upgrades to the fire safety works were in their final stages, and the provider had installed several clinical hand-wash sinks in appropriate locations throughout the designated centre.

Inspectors followed up on the provider's progress with implementing the actions detailed in their compliance plans from the previous inspections held in 2024 and 2025. While the provider had carried out several actions to address previous non-compliance's, not all actions had been fully implemented or sustained. Inspectors found recurring non-compliance's in relation to Regulations 15: Staffing, Regulation 23: Governance and management, Regulation 27: Infection prevention and control, and Regulation 9: Residents' rights. While Regulation 31: Notification of incidents was found not compliant on this inspection.

This inspection found that specific focus was now required by the provider to ensure that current management and oversight systems were effective in bringing the designated centre into compliance with the Health Act 2007 (Care and Welfare of residents in Designated centers for Older People) Regulations 2013, and to ensure that residents received a safe, well-monitored and appropriate service.

This was an unannounced risk inspection by inspectors of social services carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 (as amended). The inspectors also reviewed representation that had been submitted by the provider regarding the notice of proposed decision by the Chief Inspector to add a restrictive condition to the centre's registration in respect of appointing a person participating in the management of the centre.

Inspectors noted the provider had submitted appropriate documentation to support the removal this condition. A restrictive condition in relation to the provision of resources for the effective delivery of care in accordance with the Statement of Purpose, and the appropriate management, and supervision of staff practices in relation to infection prevention, and control had expired, and relevant information had not been submitted to the office of the Chief inspector of social services within the required timeframe for the removal or variation of this condition. Similarly, a restrictive condition in relation Fire precautions had also expired without being varied or removed by the provider. However, post inspection the provider submitted documentation in order to vary both of these conditions.

The inspectors also followed up on unsolicited information that had been received by the Chief inspector prior to the inspection. Concerns raised in these pieces of information were in relation to inadequate staffing levels, and the management of residents' end-of-life care. The information contained in these pieces of unsolicited information was found to be substantiated on this inspection. Prior to the inspection, the provider had submitted assurances with regard to the management of residents' end-of-life care, and this was validated on this inspection. However, inspectors did not find that effective measures were in place to ensure that there were sufficient staff numbers in place, to provide a consistent and appropriately supervised service.

The Health Service Executive (HSE) is the registered provider for this designated centre. The management team consists of a regional manager and a director of nursing who both provide support to the person in charge in the day-to-day running of the centre. The clinical team also consists of three clinical nurse managers, who were in position at the time of this inspection. A team of nurses, health care

assistants, household, catering, physiotherapy and occupational therapy support were also involved in the delivery of care to the residents in the designated centre.

Management and oversight by the provider had not ensured effective care delivery and safety of the service for residents. While there were monitoring systems in place, they were not always identifying risks found on this inspection, and as a consequence, there were no action plans formulated to address these risks. The provider had not ensured that risks associated with the fire safety works on the day of the inspection were adequately mitigated. Measures to protect residents from exiting the centre without staff knowledge were not adequate, and required an immediate actions on the day of the inspection. Systems to manage the risk of infection spread in the centre were not effective. A potentially communicable infection was not notified within three working days to the Chief Inspectorof Social services, as required by the regulations.

Although the number of staff available on the centre's roster was consistent with the number of staff identified in the statement of purpose (SOP), these numbers were insufficient to provide a safe and consistent service. The majority of residents living in the centre were assessed as having a maximum, or high dependency needs, and often this required the assistance of two staff members for their care. Some residents had to wait until staff became available to provide support. In addition, there were not sufficient numbers of staff available to maintain regular supervision of communal areas. This situation was compounded by levels of unplanned sickness, which impacted on the provider's ability to provide the service. The person in charge maintained records in relation to staff training, and post inspection submitted confirmation of training arranged for staff to refresh their knowledge in moving and handling. However, observations on some units found insufficient supervision of staff. Where delays in care support were occurring, there did not appear to be any plan in place as to how this issue could be alleviated and managed.

Overall, the person in charge provided the Chief Inspector with information of incidents in writing within two days of their occurrence in accordance with the regulations. However, a review of records found that two residents, and one staff member became symptomatic of a respiratory illness earlier in the year. While there was early management of these symptoms at the local level, there was no notification submitted to the Chief Inspector. Inspectors were informed by the management team that public health was informed, and consulted about these residents; however, there was no evidence made available of an infection outbreak being declared.

One complaint had been received since the last inspection. This complaints was managed effectively in line with the centre's policy on complaints, and met the requirements of Regulation 34.

Regulation 15: Staffing

There were not sufficient numbers of staff available with the required skill-mix to meet the assessed needs of the residents in accordance with the size and layout of the designated centre. For example:

- The number of staff available to support residents with their nutritional needs was not sufficient.
- Following a mealtime service on the Illankirka unit, the inspectors observed that two residents had been left in the dining room in their comfort chairs for over an hour after lunch had finished, and tables had been cleared away. The inspectors had to request that staff assist these residents, who were requesting to return to their bedrooms. When the inspector asked staff why these residents were in the dining room for an extended period of time, staff were unable to explain.
- The residents in the communal areas were left unsupervised for prolonged periods of time.
- Residents who required assistance to get out of bed in the morning had a significant wait for staff to provide the required assistance.
- There was no social care support in one unit due to due to unplanned staff sickness.

Judgment: Not compliant

Regulation 16: Training and staff development

Training records reviewed by the inspectors confirmed that staff attended mandatory training with regard to, safeguarding of vulnerable people, the management of responsive behaviours, fire safety, and moving and handling practices. Staff had also completed training relevant to infection prevention and control.

A small number of staff required refresher training which the provider was arranging at the time of the inspection.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider did not ensure that staff resources in the centre were planned, and managed to ensure person-centred, effective, and safe services. The provider did not ensure that the service had sufficient staffing resources to;

- Provide care and support to residents in a timely manner.

- Provide sufficient staff supervision for residents using communal and dining areas.
- Ensure that residents had unhindered access to a planned schedule of activities.

The oversight and management of the risk in the centre was not effective. Consequently, there were ineffective systems in place to identify, manage, and respond to risk. This was evidenced by;

- Lack of awareness of risks posed to residents during fire safety upgrades.

The arrangements in place to promote front door security were not effective in ensuring that all residents living with cognitive impairment and wandering with purpose in the centre were adequately safeguarded. The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided; however; some actions were required to ensure that these systems were sufficient to ensure the services provided are safe, appropriate, and consistent. For example:

- The arrangements in place to promote and manage interventions for infection prevention and control were not effective.
- The provider did not submit an application to the Chief Inspector in line with Section 52 of the Health Act 2007 to either vary, or remove two restrictive conditions for which the provider was due to come into compliance by the 31st December 2025.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Chief Inspector was not notified of suspected outbreaks of infection involving two or more residents who were displaying signs of infection. This was identified from the records reviewed, and by talking to staff, that these infections had occurred in December 2025 and in January 2026.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members to lodge a formal complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, and review officer, timescales for a complaint to be investigated, and details on the

appeal process should the complainant be unhappy with the investigation conclusion.

A review of the complaint's log indicated that the provider had managed one complaint in line with the centre's complaints policy.

Judgment: Compliant

Quality and safety

Inspectors found that the quality and safety of care provided to residents on a day-to-day basis were of a good standard. However, this inspection found that the systems in place to manage risk, particularly the risk associated with residents with complex care and supervision needs, were not effective, and impacted on the safety of these residents. Inspectors also found that the implementation of some residents' care plans, the management of infection prevention and control, and residents' rights were not fully in compliance with the requirements of the regulations.

Inspectors observed that the management team had made a number of improvements to the service, which included the introduction of a new medication system, improved oversight of residents' end-of-life care plans. Access to health and social care professionals had also improved since previous inspections.

Inspectors reviewed a sample of residents' care documentation. Residents' needs were in general, comprehensively assessed using validated nursing assessment tools, and care plans were found to be reviewed at regular intervals in line with the timeframes outlined within the regulations.

Residents had timely access to healthcare, and multidisciplinary professional expertise to meet their needs. A medical officer attended the designated centre daily, and there was on site support from a physiotherapist. Inspectors noted that appropriate referrals were being made to Speech and Language Therapists (SALT) and Tissue Viability Nurses (TVN), and that access to these services had stabilised, including access to on-site visits.

Overall, the centre was clean, and well-laid out for residents to use and enjoy. The communal rooms were spacious, and the corridors were wide, and contained rails fixed to the walls to assist residents with their mobility needs. Some improvements were required to the internal courtyard garden area for residents to make it more inviting, and to encourage residents, staff, and visitors to utilise the space.

The premises was undergoing fire safety upgrade in a number of bedrooms throughout the centre. The management of the safety of residents while these works were taking place was not sufficient. Inspectors had to issue an immediate action on the day to ensure that these bedrooms were securely locked. Inspectors

found these bedrooms were open when unattended, and contained building equipment, and tools which posed a risk to residents should they enter these rooms. One resident who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) was not provided with the required level of supervision. They were found entering into other residents' rooms without staff intervention.

Residents' nutritional care needs were being monitored. Care plans contained adequate information to guide care. Residents' weights were monitored, and there were appropriate referral pathways in place for the assessment of residents identified as being at risk of malnutrition.

However,the inspectors observed a mealtime experience, and found that additional supervision, and resources were required to ensure residents' dining experience was appropriate, and enjoyable. There were insufficient staff resources available in one dining room, which meant that residents had to wait longer for staff support. Observations confirmed that residents who required the support of staff with their eating, and drinking were not provided with timely support which resulted in their food getting cold before they had the opportunity to consume their meal.

The provider had introduced a tagging system to identify equipment that had been cleaned. However, this system had not been consistently implemented at the time of inspection. For example, several items of shared equipment had not been tagged after cleaning, and tags were not removed before using a some items of equipment. On the other hand, the provider installed a number of clinical hand-wash sinks to promote effective hand hygiene.

Since the last inspection, the provider introduced a new medication management system, which had improved staff administration practices, and reduced medication errors. This was also supported by the local pharmacy, who visited the centre to provide advice and guidance. The provider maintained their efforts to upgrade fire safety facilities in the centre. The programme of works was entering its final phase with an estimated completion date at the end of March 2026. A review of fire safety records found that the provider maintained daily, and weekly checks of the fire system. Simulated fire drills, and resident emergency evacuation plans (PEEPs) supplemented the centre's fire procedures.

While there was a well-organised schedule of activities advertised in the designated centre it was not always possible for to deliver the programme as advertised. This was due to the activities staff having to provide care support to residents when there was a shortage of staff. As a result, these arrangements were negatively impacting on the delivery of social care support to provide activities, and stimulation for residents, in accordance to their interest and capabilities. There were also limitations on residents' ability to choose when they wanted to get up in the morning. Residents who required staff assistance to begin their days in the morning had to wait until staff became available, and meant that this was not in keeping with their preference as set out in their care plans.

Regulation 13: End of life

Appropriate care and comfort was provided for residents approaching their end of life. Residents' end-of-life care plans were in place to guide staff in their care, and were found to be person centred.

Staff were knowledgeable about the care and comforts required, and had attended specific training relating to end-of-life care. Care plans reviewed gave information in respect of their specific end-of-life preferences to inform decisions of care, and effectively address the person's individual physical, emotional, social, psychological, and spiritual needs.

Judgment: Compliant

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out under Schedule 6 of the regulations. For example:

- The courtyard garden area for residents' use was uninviting, and in need of painting, and refurbishment.
- There were inadequate storage arrangements for healthcare equipment in the first floor store room. Inspectors observed that many items in need of repair or removal were stored along with clean healthcare equipment, and clinical supplies that were in currently being used in the centre.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The dining experience and nutritional support and assistance provided for residents in this centre was not consistent. The inspectors observed that there was not enough staff support provided for residents in the Illangrove unit with their meals. The inspectors observed one staff member assisting a resident with their meal, who was interrupted on several occasions to attend to other residents requiring assistance.

Furthermore, the inspectors sampled two meals from the serving trolley in each dining room, and found that the food available, a poached salmon and a loin of

bacon was lukewarm. Residents confirmed to the inspector that the food served to them in their bedroom was not hot.

Judgment: Not compliant

Regulation 26: Risk management

There is a risk management policy in place which contained all of the requirements of the regulation. Risk assessments were maintained by the provider to mitigate identified risks, and included control measures to minimise or eliminate the risk present. Some risks found on this inspection did not have controls in place to reduce the risk identified, these are discussed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 27: Infection control

Notwithstanding some good infection prevention, and control practices, the inspectors observed that the storage of clean, and dirty equipment was poorly segregated. This increased the risk of cross contamination. Other examples of poor practice found on the day included:

- Several commode basins, and urinals were visibly unclean on the drying racks in the sluice room. Other equipment such as commodes, and comfort chairs were observed to be visibly unclean.
- Generic hoist slings were observed in the laundry room which were not labelled for specific, and individual residents use. This increased the risk of infection spread when used between residents.
- Staff confirmed that they did not consistently change their clothes when arriving to work or when leaving. This increased the risk of infection spread.

Judgment: Substantially compliant

Regulation 28: Fire precautions

At the time of this inspection, the registered provider was working towards addressing fire safety deficits identified in previous inspections and in their fire safety risk assessment carried out in February 2023. Fire safety upgrades were

nearing completion, which would bring the provider back into compliance with this Regulation. The outstanding works found on this inspection related to:

- The completion of fire stopping service penetration issues to prevent the spread of smoke, and fire in the event of a fire emergency.
- Risks associated with the fire safety upgrades found on the day were not well-managed, and required the issue of an immediate action to safeguard residents.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Processes were in place for the prescribing, administration, and handling of medicines, including controlled drugs, which are safe and in accordance with current professional guidelines, and legislation. A sample of medication charts was reviewed, and all medications had been given as prescribed. No errors or omissions were identified. Regular audits of medication management were completed, and staff had completed training in medication management. Safe administration practices were observed on this inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident in the centre. A pre-admission assessment was completed prior to admission to ensure the centre could meet the residents' needs. All care plans reviewed were personalised, and updated regularly, and contained detailed information specific to the individual needs of the residents. Comprehensive assessments were completed, and informed residents individual care plans. Care plans were seen to be updated at regular intervals or as and when required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Although the person in charge ensured that staff had adequate knowledge, and training to respond, and support residents presenting with responsive behaviours

the measures in place to safeguard these residents were found to be ineffective on the day of the inspection.

This meant that residents who were presenting with responsive behaviours may not be responded to or managed in a manner that provided the required level of support required. For example:

- A resident with a cognitive impairment was observed wandering into other residents bedrooms uninvited, and mobilising around other areas of the centre unsupervised.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The systems in place to ensure compliance with Regulation 9 did not ensure that residents' rights were fully upheld in all areas of the service. For example:

- Although there was an activity programme available in the designated centre, on the day of inspection there was one activity coordinator available during the morning to provide social care support to 41 residents located across two floors in four separate units. A second activity coordinator was called in to support, and provide activities for residents in the afternoon.
- While there is an interesting schedule of activities for residents to participate in, staff coordinating these activities were regularly interrupted in their role, and called away to provide assistance with personal care as requested by residents. This meant that when the activity coordinator was assisting these residents, residents who were participating in these activities had to wait for their return to resume the activity.
- The use of partial portable privacy screens in the twin-occupancy rooms remained a concern, as they did not ensure residents' privacy was protected.
- The inspectors observed that a significant number of residents requiring the assistance of two staff in the Illankirka unit were still in bed at 11:30 am, this was not in line with their requirements, and preferences set out in their care plans. Six residents out of 11 residents on this unit were found awaiting assistance from staff to begin their day prior to lunch being served at 12:30pm.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Virginia Community Health Centre OSV-0000503

Inspection ID: MON-0045648

Date of inspection: 05/02/2026

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 Provider will come into Compliance with Regulation 15: Staffing as follows :

The Provider will come into Compliance with Regulation 15: Staffing, as follows:
Three Health Care Assistants have agreed start dates of 20th April 2026 and 5th May 2026. Two Health Care Assistants are in Pre-employment Clearance and the remaining vacant Health Care Assistant positions have been offered out to Panel.
Staff Nurse Interviews commenced on 23rd March 2026 and will be completed on 9th April 2026. All vacant Nursing positions in the Designated Centre will be offered out to this Panel. (30/09/26)

The Management Team in the Designated Centre have carried out a review of staff mealtimes to ensure all staff are available on both the ground floor and the first floor to support and assist residents with their meals. This will also ensure that there are sufficient staff are available to take residents from the dining-room to the sitting-room, other communal area or their bedroom as per each residents individual choice. (09/02/26)

A staff rota for supervision in communal areas will be drawn up and implemented in the Centre. (13/04/26)

• At morning Handover the Clinical Nurse Manager / Senior Staff Nurse in Charge provide all staff with a copy of the Ward Handover sheet detailing measures in place to reduce the Risks of Falls, Residents identified as having Responsive Behaviours, Resident's Modified Diets, Resident's MUST Score, IPC issues, new TVN concerns, Restrictive Practices, Resident's on antibiotic therapy, residents at end of life, any wandering / absconding risks, Chocking risks, appointments and referrals and Respite Admissions.
• To ensure sufficient staff are available in the Centre to provide timely care and support to residents in the morning, the Centre will continue to utilise Regular Agency Staff with appropriate Qualifications, who are fully Garda Vetted and whose Mandatory Training is

up-to-date and roster them on the Centre's staff roster. These staff will be provided with appropriate induction to day to day life in the Designated Centre, to Fire Safety and Fire Evacuation Procedures, Resident's individual Care Plans.
• All staff will be supported and monitored by the Clinical Nurse Manager to ensure safe, effective and appropriate care is provided to residents, based on their assessed needs, Care Plan and will and preference.

• In the event of short term sick leave absence for social care support staff, the Management Team will contact off-duty staff to request them to cover the provision of social care support to residents.
• If no staff are available from the Centre's staff, the Management Team will contact regular Agency Staff to provide cover.

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 will come into Compliance with Regulation 23: Governance & Management by the following:

Three Health Care Assistants have agreed start dates of 20th April 2026 and 5th May 2026 and 18th May 2026. Two Health Care Assistants are in Pre-employment Clearance and the remaining vacant Health Care Assistant positions have been offered out to Panel. Staff Nurse Interviews commenced on 23rd March 2026 and were completed on 9th April 2026. All vacant Nursing positions in the Designated Centre will be offered out to this Panel. (30/09/26)

The Management Team in the Designated Centre have carried out a review of staff mealtimes to ensure all staff are available on both the ground floor and the first floor to support and assist residents with their meals. This will also ensure that there are sufficient staff are available to take residents from the dining-room to the sitting-room, other communal area or their bedroom as per each residents individual choice. (09/02/26)

A staff rota for supervision in communal areas will be drawn up and implemented in the Centre. (13/04/26)

Applications in line with Section 52 of the Health Act 2007 to either Vary or remove restrictive conditions will be submitted to the Chief Inspector in a timely manner.
• Going forward all Risks / potential Risk will identified on the Designated Centre's Risk Assessment and Risk Register and will be appropriately monitored and managed by the Clinical Nurse Manager, with Clinical Oversight by the Person in Charge.

• A Safety Champion is identified on the staff roster each day. They carry-out a daily walkabout on the ward to identify any risk / potential risk and they record same on the ward's Safety Pause Record.
• The Designated Centre has two Trained Health & Safety Representatives who carry out monthly Safety Representative Checklists in the Centre.
• Findings are brought to the attention of the Person in Charge who actions accordingly.
• Safety Pause is held daily on each ward. All identified risk / potential risks are communicated to all staff at the Safety Pause.
• All identified risks are brought to the attention of the PIC daily for action.
• Actions required and actions completed are recorded on the safety pause record on each ward.
• All required actions are monitored by the PIC until complete.
• The Designated Centre has a local Health & Safety Committee in operation in the Centre who meet quarterly to discuss findings of Inspection Checklists, discuss progress to date and review any further actions required. The Catering Manager and the General Operative for the Building also attend these meetings.

• To ensure sufficient staff are available in the Centre to provide ongoing care and support to residents until a full staff team is recruited, the Centre will continue to utilise Regular Agency Staff with appropriate Qualifications, who are fully Garda Vetted and whose Mandatory Training is up-to-date and roster them on the Centre's staff roster. These staff will be provided with appropriate induction to day to day life in the Designated Centre, to Fire Safety and Fire Evacuation Procedures, Resident's individual Care Plans.
• Agency staff will be supported and monitored by the Clinical Nurse Manager to ensure safe, effective and appropriate care is provided to residents, based on their assessed needs, Care Plan and will and preference.
• The Designated Centre is supported from an IPC perspective by two Clinical Nurse Specialists in Infection Prevention & Control.
• There are four IPC Link Nurses working in the Designated Centre who
Carry out MEG Environmental Audits in the Designated Centre bi-weekly on each ward (total 4 per month), they carry out Hand Hygiene Audits with staff and residents, they deliver education sessions to all staff and they ensure all up-to-date IPC Guidance is available on each ward.
Quality Improvement Plans are implemented in respect of any actions required.

The Person in Charge has clinical oversight of the QIP until completed.
The IPC Link Nurses attend ongoing support forums facilitated by Sligo, Leitrim, Donegal IHA.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Registered Provider will come into Compliance with Regulation 31: Notifications of Incidents as follows:
The Person in Charge will notify the Chief Inspector, in a timely manner of any suspected or confirmed Outbreak of Infection involving two or more residents who display symptoms of Infection. (06/02/26)

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Internal Courtyard is scheduled to be power-washed and painted.(31/05/26)

A schedule of cleaning and painting of the courtyard shall be maintained by the Person in Charge and will be available for the Inspector to review on request. (30/04/26)

The Person in Charge has sourced decorative garden ornaments and wall decorations for this area and is awaiting delivery of same.(31/05/26)

The Centre has comfortable Garden Furniture for residents to sit and relax in this area and will be available in the courtyard (weather permitting) from 31/05/26.

Residents will begin to plant seasonal flowers (over the coming weeks) in pots which will be displayed in the Courtyard and throughout the Designated Centres outdoor areas.

The Designated Centre has in place a New System for the recording and monitoring of items / equipment "in use", "for repair" and "in storage". (28/02/26).

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The Management Team in the Designated Centre have carried out a review of staff mealtimes to ensure all staff are available on both the ground floor and the first floor to support and assist residents with their meals. This will also ensure that there are sufficient staff are available to take residents from the dining-room to the sitting-room other communal area or their bedroom as per each residents individual choice. (09/02/26

The Chef on duty will check and record that setting on the Hot Food Trolley when leaving the Kitchen to transport meals to the Ward Pantry's / dining-rooms for food service. The Senior Staff Nurse on duty will check and record the setting on the Hot Food Trolley on arrival in the Pantry / dining-room before meal service. The Hot Food Trolley will be maintained at "10" on the heat dial on the trolley. (06/04/26)

The Person in Charge and the Clinical Nurse Managers in the Designated Centre have completed the Clinical Leadership Development Programme for Managers which will ensure the ongoing and effective oversight of all staff resources to ensure residents are appropriately supervised and supported with their nutritional needs."

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The Provider will come into Compliance with Regulation 27: Infection Control by:

A red sticker "I need to be cleaned" will be placed on all items / equipment waiting to be cleaned / sterilized. (09/02/26)

All residents in the Designated Centre have their own individual slings, measured to their individual requirements for use when moving / repositioning.

As part of morning Handover, the CNM II / Senior Staff Nurse will nominate a Health Care Assistant to go to the Laundry Room to check and ensure there are no inappropriate items in the Laundry room.

The Designated Centre operates a non-uniform policy for staff. Staff are advised and encouraged to change their clothing before and after commencing duty. Notice reminding staff have been placed in staff restrooms, changing facilities and on the entrance / exit door of the Centre.
Staff will also be reminded of this IPC requirement during the Centre's daily Safety Pauses and at Ward and Centre Staff Meetings. Records of same will be available to the Inspector on request.(06/04/26)

• Equipment used for resident's toileting is taken to the Sluice room for decontamination in the steriliser.
• Items waiting to be placed in the steriliser are placed on the sluice draining board and an "I need to be cleaned" sticker placed on same to alert staff that this piece of equipment needs to be sterilised prior to use or storage.
• Equipment used for the residents' mobility and transfer are cleaned after each use and

an "I am clean" sticker is placed on same to alert staff that this equipment is clean and ready for use.
• All residents living in the Designated Centre have individual slings which are clearly labelled with the resident's name. Respite clients are provided with an appropriately fitting sling which is temporarily labelled with their name for the duration of their stay in the Designated Centre. This will ensure that all slings/belts are laundered and appropriately stored to avoid cross contamination.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider will come into Compliance with Regulation 28: Fire Precautions by the following:

The External Contractors have completed on-site works.(01/04/26)
The Contractor is awaiting the delivery of three Fire Doors, two door for toilets on the first floor and one door for the Laundry room. There is a lead in time for the delivery of these door onsite of 4 to 6 weeks. The current toilet and laundry room door are 30 minute Fire Doors and the new doors when fitted will be 60 minute Fire Doors. These door will provide increased fire resistance. (25/05/26)
There are some snag items to be completed. These are minor issues such as sanding and paint touch-up.
The Fire Consultant has issued a Substantial Completion Certificate to the Provider on 15th April 2026. Copy of same attached for reference.

The Clinical Lead for Quality, Risk and Training will be providing the Clinical Nurse Manager with additional supports in relation to Risk, Identification of Risks & Risk Assessments, Incident Management and Safeguarding. (30/04/26)

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
All staff working in the Designated Centre have received up to date Training in the Prevention and Management of Complex Behaviours.

The Clinical Lead for Quality, Risk & Training is also a Qualified PMCB Instructor as are two of the Clinical Nurse Managers from within Services for Older Persons Cavan Monaghan. They are available to advise, guide, support staff and residents in managing complex behaviours.

A resident who displays Complex Behaviours has an Active Behavioural Support Care Plan supported by appropriate Risk assessments and Behaviours monitoring Tools.

In the Designated Centre we support our residents in positive risk taking in order to self-determine and maximise opportunities to live a full and valued life.

The External Contractor has fitted a new Key-pad system on both the front and back entrance doors (03/04/26).

A staff rota for supervision in communal areas will be drawn up and implemented in the Centre. (13/04/26)

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Provider will come into Compliance with Regulation 9: Resident's Rights by:
The Designated Centre has in operation a schedule of weekly activities for residents based on their interests and capacities. Residents are free to choose to participate or to decline to participate in any of these activities on any given day or time.

The Provider will come into Compliance with Regulation 15: Staffing, as follows:
Three Health Care Assistants have agreed start dates of 20th April 2026 and 5th May 2026. Two Health Care Assistants are in Pre-employment Clearance and the remaining vacant Health Care Assistant positions have been offered out to Panel.
Staff Nurse Interviews commenced on 23rd March 2026 and will be completed on 9th April 2026. All vacant Nursing positions in the Designated Centre will be offered out to this Panel. (30/09/26)

This will ensure adequate staff are available to support residents with personal care as requested by residents and ensure that staff co-ordinating activities are not disrupted from doing so. This will also ensure that residents receive personal care in a timely manner and to ensure that residents are appropriately supervised and supported with their social and nutritional needs. (30/09/26).
The Person in Charge, the Service Manager (PPIM) and the Director of Nursing carried out a review of the Privacy Screens, including the additional portable privacy screens in the twin-occupancy rooms to ensure that they were fully compliant with providing residents with privacy and dignity. (01/04/26)

• In the event of short term sick leave absence for social care support staff, the Management Team will contact off-duty staff to request them to cover the provision of social care support to residents.
• If no staff are available from the Centre's staff, the Management Team will contact regular Agency Staff to provide cover.
• One designated HCA from each ward will attend the activities Programme to assist and support residents with personal care as requested by residents.
• The staff member attending the Activities programme to support resident's personal care needs will be clearly identified on the staff roster each day.

• All staff will be supported and monitored by the Clinical Nurse Manager to ensure safe, effective and appropriate care is provided to residents, based on their assessed needs, Care Plan and will and preference.

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	30/09/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/05/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Substantially Compliant	Yellow	06/02/2026

	and drink which are properly and safely prepared, cooked and served.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Orange	09/02/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/09/2026
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	14/04/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are	Substantially Compliant	Yellow	06/04/2026

	implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	25/05/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	30/04/2026
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	06/02/2026
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.	Substantially Compliant	Yellow	09/04/2026
Regulation 9(2)(b)	The registered provider shall provide for	Not Compliant	Orange	30/09/2026

	residents opportunities to participate in activities in accordance with their interests and capacities.			
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.	Not Compliant	Orange	01/04/2026