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:	Sacred Heart Hospital
Name of provider:	Health Service Executive
Address of centre:	Old Dublin Road, Carlow, Carlow
Type of inspection:	Unannounced
Date of inspection:	16 April 2026
Centre ID:	OSV-0000549
Fieldwork ID:	MON-0049520

About the designated centre

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

Sacred Heart Hospital is a 63-bed facility located within walking distance of Carlow town centre. Residents' accommodation is arranged in three interconnecting units. The units are Sacred Heart unit has 20 beds, St Clare's unit has 21 beds, and St James' unit has 22 beds. The centre provides care for male and female residents over 18 years of age with continuing care, dementia, respite, palliative care and rehabilitation needs. The centre is registered to provide 44 long-term and 14 rehabilitation beds, including two respite bed for dementia care, two community assessment beds and three short-stay beds. Residents' accommodation is arranged at ground floor level in 14 multiple occupancy bedrooms with four residents in each, one twin bedroom and five single bedrooms. There is a combined communal sitting and dining room in each unit. The provider employs nurses and care staff to provide care for residents on a 24-hour basis. The provider also employs GP, allied health professionals, catering, household, administration and maintenance staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	60

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 16 April 2026	08:30hrs to 17:00hrs	Niamh Moore	Lead
Thursday 16 April 2026	08:30hrs to 17:00hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The overall feedback from residents was that Sacred Heart Hospital was a nice place to live. Inspectors observed warm, kind, dignified and respectful interactions with residents throughout the day by all staff and management. Feedback received by inspectors from residents was very positive, with comments such as "I am content with everything" and "I am very happy with the care provided" and "I have no complaints".

This was an unannounced risk inspection, which took place over one day by two inspectors of social services, including one inspector who focused on the provider's compliance with the premises and fire precautions including the oversight of these areas.

Inspectors arrived to the centre at 08:30am and following an introductory meeting with two members of the management team, completed a walk around of the premises with the person in charge. Sacred Heart Hospital is a single-storey building divided into three residential units, St James', St Clare's and Sacred Heart. All units were set up with dining and day spaces, and there was additional communal space available outside these units such an oratory, a hairdressers and a room where larger group activities were held for residents of all three units, such as live music.

The centre is registered for 63 residents, with 60 residents on the day of the inspection. The St James' unit has occupancy for 22 residents and supports residents for long-stay, rehabilitation and community assessment/respite. Residents' bedroom accommodation was in five four-bedded rooms and two single bedrooms. St Clare's unit has occupancy for 21 residents and supports residents for long-stay and respite. Residents' bedroom accommodation was in five four-bedded rooms and one single bedroom. The Sacred Heart unit has occupancy for 20 residents and supports residents for long-stay. Residents' bedroom accommodation was in four four-bedded rooms, one twin-bedded room and two single bedrooms. All bedrooms had en-suite facilities. Bedrooms were clean, and inspectors saw that each resident had storage including a lockable space to safe keep their belongings. Residents spoken with said they were happy with their bedrooms.

Inspectors observed some areas of the internal premises were decorated to an appropriate standard. However, following extensive leaks, remedial works were underway to the external roof during this inspection. Inspectors saw that one large section of this work was completed, and an interim measure was in place to protect the roof in another large section. Inspectors saw where the leak had damaged the ceilings in the residents' bedrooms, these had been repaired and repainted. However, a number of non-residential areas including staff offices, store rooms and a staff canteen had works outstanding.

As outlined in the previous report in August 2025, some of the internal courtyards required garden maintenance to make these areas a safe and pleasant area for resident use. Inspectors noted these areas had not yet been progressed but were told by management that this was part of the budget this year to ensure these works were completed, and this was in line with the compliance plan date.

In addition, inspectors found some repeat concerns related to fire safety which had also been identified at the last inspection, and while the provider had committed to addressing these as part of their compliance plan some had not been completed within the timeframes set out. This included directional signage which was incorrectly sign-posting to areas which were not fire exit points. This created a risk that those unfamiliar with the building would have a delayed exit in the case of an emergency. This will be further discussed within this report under Regulation 28: Fire Precautions.

Residents were observed to be being supported with personal care in the morning of the inspection. At times of personal care provision, resident's bedroom doors were closed and for the multi-occupancy rooms, the privacy curtains were closed, maintaining residents' privacy and dignity. Throughout the day residents were seen in both communal areas and their bedrooms. Some were observed mobilising around the centre independently or, where required, support was provided by staff.

There was information on display for residents such as the complaints procedure, advocacy and safeguarding measures. An activities schedule was also on display throughout the centre. There was a good variety of activities for residents to choose from Monday to Sunday which included chair yoga, dog therapy, live music, and cooking, with pizza making occurring the week of the inspection. There was also one-to-one activities available for residents who preferred smaller groups such as nail painting, short-stories and colouring. Resident's reported to enjoy the activities that were on offer.

Inspectors observed the lunchtime meal on the day of the inspection where residents were offered a choice of chicken or corned beef. Dessert options included apple tart and custard or ice-cream. Meals were pleasantly presented and looked appetising. There were enough staff on duty to support residents at meal times, and those who required assistance with their meals received support from staff in a respectful and dignified manner and were not rushed. Five residents spoken with confirmed they enjoyed their meals, reporting that the food was very good.

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

Capacity and capability

Overall, there were management systems in place to ensure residents were provided with quality care and support. However, not all areas of the service was effectively monitored, particularly relating to the oversight of the premises and fire precautions.

This was an unannounced inspection. The purpose of the inspection was 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). The inspectors also followed up on the compliance plan from the previous inspection, and information received by the Chief Inspector of Social Services since the last inspection in August 2025.

Sacred Heart Hospital is owned and operated by the Health Service Executive. A manager of older person's services and the general manager for Older Person's Services for the CHO5 area were the persons delegated by the provider with responsibility for senior management oversight of the service.

There had been some changes to the management structure since the previous inspection. The person in charge had left and a new person in charge had been appointed and notified to the Chief inspector for an interim measure of four weeks until a permanent candidate was appointed in May. The interim person-in-charge worked full-time in a supernumerary capacity and previously held the role of the assistant director of nursing for the centre.

The person in charge was supported in their role by two assistant directors of nursing and each unit had a clinical nurse manager (grade two) and a clinical nurse manager (grade one). Nursing staff were supported by healthcare assistants, activity staff, household and catering staff. The designated centre was also supported by medical officers, allied health professionals, a dementia nurse and administrative staff.

At the time of this inspection, there were a number of staff vacancies in the centre. A mix of agency staff and the centre's own staff were currently filling gaps in rosters, including some staff stepping up to fulfil temporary management posts. Inspectors were told that the registered provider was making efforts to secure the same agency staff as much as possible to promote continuity of care and the use of familiar staff in the centre for residents while recruitment was ongoing.

There were roles and responsibilities established within the management structure that identified the lines of authority and accountability. There were oversight systems in place to monitor the service provided, which included meetings, key performance indicators and auditing. However, inspectors found that these systems did not always identify areas that required improvement, and in some cases despite improvements being identified they were not fully actioned. For example, inspectors found that the registered provider had not actioned all aspects of the compliance plan they committed to following the previous inspection, and therefore resulted in repeat findings being identified on this inspection. The oversight measures relating to Regulation 17: Premises and Regulation 28: Fire Precautions were also not fully-

effective. This is further outlined under Regulation 23: Governance and Management.

Regulation 14: Persons in charge

The person in charge had the relevant experience and qualifications as required by the regulations. For example, they are a registered nurse with experience in the care of older persons and hold a post registration management qualification.

Judgment: Compliant

Regulation 21: Records

Following up on the compliance plan from August 2025 inspection, residents' records were seen to be securely and safely stored throughout this inspection. For example, the clinical room was locked when not in use and care records were not stored outside bedrooms.

Judgment: Compliant

Regulation 23: Governance and management

While the registered provider had some assurance systems in place regarding the quality and safety of the service, a number of areas were identified that required action. This was evidenced by:

- The provider had set out timebound actions to address the issues identified on previous inspections regarding complaints, records for all transfers, the premises and fire precautions. However, inspectors found that these issues had not been addressed and remained on this inspection.
- The resources to support the maintenance of the designated centre required strengthening. Numerous areas of wear and tear were seen on this inspection to include paint-work, worn flooring and the external garden areas which required maintenance attention.
- Remedial works to damaged ceilings require review to ensure the original fire rating is fully restored, as repairs involved structural elements rather than cosmetic fixes.
- Inspectors reviewed the previous fire safety risk assessment which was dated 2011 and noted that some issues identified had not been implemented. Review and sign-off by a competent was required on the works completed to

the ceiling and roof to provide assurance that the remedial works completed did not impact on compartmentation of the ceilings and walls.

- Audits were being carried out but were not effective and did not align with the findings of this inspection for example, during the morning walk-around, inspectors identified a number of areas which had partially blocked access to escape routes externally. It is acknowledged these were responded to during the inspection when brought to their attention.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a record that staff were supported to attend complaints management training, however a repeat finding was found that there was no record that the review officer had received suitable training to deal with complaints in accordance with the regulations.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that residents had a good quality of life and were supported by staff to have their rights' respected and to be included in decisions about their care. However, improvements were required in some areas of the quality and safety of the service, including that of care records, the premises and fire precautions.

Inspectors reviewed a sample of ten care records, and observed many examples of good detailed person-centred care plans that reflected residents' assessed needs. In addition, there was evidence that records were reviewed in line with regulatory timeframes, and had been discussed and created with residents and where relevant their families. However, there were some gaps seen in care plans reflecting residents assessed needs and ensuring all care was delivered in line with care plans, this is further outlined under Regulation 5: Individual assessment and care plan.

Residents had their rights promoted within the centre. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents' forum meetings which discussed a variety of topics. In a review of these minutes, inspectors saw that residents provided high praise for the food and mealtimes, the activities and the staff. There was evidence that the recent works to the roof were also discussed in some of these meetings. Residents had access to radio, television and newspapers. Residents also

had access to independent advocacy services with some residents availing of these supports. All residents spoken with reported to feel happy and safe within the centre.

The laundry service was off-site with set collection and return dates in place. There were systems for tagging resident's clothing to ensure it was returned to the correct resident.

The premises of Sacred Heart Hospital is extensive, and forms part of a larger health service campus at the site. The nature of the arrangement whereby maintenance staff responded to requests from nursing home staff as they arose, required review, as ongoing maintenance checks, environmental audits, and preventative maintenance was not being carried out to the level required for a large building with known issues. The extent of the issues with the existing roof, were long-standing, and ongoing. Temporary measures were in place above resident bedroom blocks however, significant areas of the centre including offices, staff changing rooms and previous therapy rooms had evidence of extensive damage to the ceilings and walls as a result of water ingress. The resident bedroom blocks had their ceilings and walls repaired, and a temporary tarpaulin (plastic sheeting) type material was stretched over the roof and anchored at ground level to prevent rain hitting the roof. While this was working as an interim measure, it was causing damage to the edges of the roofs, and was causing partial obstructions on walkways surrounding the building. The provider had taken the step of vacating all of the remaining affected areas until remediation works were complete, which meant water continued to penetrate these areas. This was resulting in mould developing and a deterioration of the buildings structure in some areas. Maintenance issues are discussed in more detail under Regulation 17: Premises.

Inspectors reviewed the arrangements in place to protect residents from the risk of fire. The entire nursing home is laid out on the ground floor with exits available along corridors, and compartmentation of those corridors in place. However, the provider had in place a system of progressive horizontal evacuation using the resident's beds in the event of a fire. During this inspection, inspectors noted concerns which would impact on this system including doors which were not wide enough to fit a bed, doors which would not open sufficiently to evacuate, and obstructions on escape routes. The system of evacuation also relied on compartmentation of areas of the centre, and the protection of the escape corridors. Inspectors found this method of evacuation was compromised by non fire rated cabinets which housed high fire risk items such as electrical switch boards which were located along evacuation corridors. Nurses' stations were open to the corridor which allowed a free flow of engagement and supervision between staff and residents, however, the number and nature of materials placed in these nurses stations resulted in an increased risk of fire within the escape routes.

Emergency lighting required review as it was inconsistent and gave inaccurate direction in some cases which could hamper an evacuation in the event of a fire. These and other fire related concerns are discussed in detail under Regulation 28: Fire Precautions.

Regulation 12: Personal possessions

Residents were supported in accessing and retaining control over their personal property and possessions. Residents had sufficient space to store and maintain their clothing and possessions.

Judgment: Compliant

Regulation 17: Premises

The registered provider, having regard to the needs of the residents at the centre, did not provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- The premises was not kept in a good state and sound construction. A finalised plan of when all of the remedial works to the roof, the guttering, internal ceilings and walls was required. These works were necessary as a result of the long standing roof repairs and remedial works. This is a repeat finding
- Internal courtyards required a full review and repair, as some concrete planters and seats along walkways were broken or extensively cracked. Some of the paving was uneven and the garden area required maintenance attention in general. This was a repeat finding.
- A review of resident sinks within their bedroom en-suites was required as many of these rooms did not have a plug to allow residents to use the sink effectively.
- Emergency call bells were not in place in all areas. Some areas had a doorbell type system in place which differed substantially from the existing call bell system and would not remain "on" until assistance arrived. This issue had been raised on a previous inspection.
- A kitchen in an activities room was damaged at the cabinets and some appliances were in the process of being replaced.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

Following up on the compliance plan from August 2025 inspection, inspectors found that sufficient action had not been taken to ensure a record was kept of all relevant information provided about the resident who is temporarily absent from Sacred Heart Hospital to the receiving designated centre, hospital or place. For example, on

the day of this inspection there was one resident temporarily in hospital and there was no copy of the transfer letter available for this resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the registered provider to take adequate precautions against the risk of fire, and to provide suitable means of escape, emergency lighting, and ensure staff were familiar with the actions to take in the event of a fire for example:

- The registered provider did not provide adequate means of escape, including emergency lighting, for example:
    - An exit door from an escape corridor was not working at the time of inspection. When this was brought to the attention of staff, maintenance was called and later in the day, a temporary repair was made so that the door would open. A review of the doors and the fastenings of the exit doors was required to ensure they remained readily openable at all times in the event of a fire.
    - Emergency lighting required review. In a number of areas, the emergency lighting directional signage was pointing into a room which did not provide an exit route. This would cause confusion and delays min the event of a fire. Emergency lighting had been highlighted as a risk at this centre on the fire safety risk assessment in 2011.
- A review of the fire drills was required. Documentation viewed found that while fire drills were being conducted at the centre regularly, the drills did not reflect the evacuation of the entire compartment.
- Even though bed evacuations were being practiced and were discussed as the preferred method of evacuation, all resident beds were fitted with evacuation sheets. These sheets assist in the evacuation by providing a method for evacuating the resident on the mattress of the bed. However, on the day of inspection, only 18 staff were trained in the use of these ski-sheets, and there was no clear indication in policy or procedure of when these would be used. There was no record of checking of the ski-sheets being completed to ensure that they would function effectively if required

The registered provider did not make adequate arrangements for detecting or containing fires. For example: There were findings in relation to poor detection, poor fire protection in high risk rooms (including communication rooms), doors such as the kitchen door which could not close due to the "pull" effect from the extractor fan within the kitchen. An overall review of compartmentation and fire doors was required.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Following up on the compliance plan from August 2025 inspection, medicines were seen to be stored securely throughout this inspection.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Following a review of a sample of comprehensive assessments and care plans. Improvement was required to ensure that care plans reflected the current assessed needs of residents, and included information which sufficiently guided staff in providing good quality care. For example:

- A wound assessment was not completed in line with the resident's care plans. For example, the care plan outlined wound dressings should be done every day, however from a review of documentation there were gaps in the assessments seen on one occasion for four days and on another occasion for five days.
- Two wound care plans evidenced that pain should be monitored and PRN (as required) pain relief given 45 minutes prior to dressing changes, however while pain assessments were completed daily they were routinely done in the morning and not as outlined within the care plans to ensure this pain relief was provided. In addition, wound assessments noted pain on six occasions.
- A safeguarding care plan referred to organisational safeguarding measures and did not identify the specific safeguarding risks of the resident to guide staff on their individual needs.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had ensured that residents' rights were upheld to include adequate facilities and opportunities to engage in activities, communicate freely and participate in the running of the centre.

Improvements had been actioned following the last inspection, with a procedure to ensure residents had timely access to their finances Monday to Sunday within the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sacred Heart Hospital OSV-0000549

Inspection ID: MON-0049520

Date of inspection: 16/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Not Compliant

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

• The upkeep and maintenance of the Centre is ongoing and a planned scheduled décor upgrade of Sacred Heart Hospital was undertaken in late 2025 and completed in November 2025. As a result of the roof repair works, a programme of repair and maintenance has been initiated to coincide with progression works. Issues including damaged doorframes, scuffed walls and ceiling defects have been logged and are being addressed under the centre's maintenance plan. Painting will commence in July 2026 in the areas where roof repairs have been completed with further areas being addressed as roof repairs progress. The upgrade and repair of the roof in the centre involves a major scope of works and the project continues to progress. The project is divided into 3 phases with phase 1 completed April 2026. Phase 2 is currently at tender stage with a tender return date of July 20th 2026 and a design team to assess the project by 31/07/2026 and contractor appointed in early August 2026. Phase 2 encompasses all resident areas and projected time line for completion of phase 2 is Dec 2026.
The 3rd phase encompasses the front of the building, administration section and will commence early 2027 and expected date of completion is Q2 2027. – Planned completion July 2027
• Maintenance log books have been introduced to each area to strengthen the response from maintenance works logged. The current wear and tear areas are being addressed with a painter onsite presently commencing in Sacred Heart Unit and progressing through to the remaining 2 units with a planned date of completion end of October 2026.The worn flooring has been logged and will be repaired with a planned completion date of October 2026. The external gardens have been reviewed and are currently under the tender process for an upgrade with a projected completed date of December 2026.
• Complaints review officer training cert and record is up to date and now retained on site. - Completed
• All residents that are transferred to the acute services have a National transfer document completed and a copy is retained in their file. All documentation that supports

a resident's transfer is maintained in their file. CNM on each unit has oversight of resident transfer to the acute services supported by the ADON.
A new check list has been included on the daily safety pause to ensure compliance - Completed
• The repair of the ceilings is included in the review of the fire upgrade works and will be included within the revised fire certification.
• A fire safety risk assessment has been requested and awaiting confirmation of date of same to be carried out. Proposed before end of Quarter Four 2026
• Fire safety is now included in the daily safety pause to include all fire exit routes clear and signed off with oversight from nursing management. - Completed

Regulation 34: Complaints procedure	Substantially Compliant

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

The centre has an identified Complaints Officer and Review Complaints Officer. The centre has an up to date policy in place. The contact details and the identity of the complaints officer is visual throughout the centre. Each unit has a complaints /concern log book. All complaints received are discussed and recorded for minutes at monthly CNM meetings regarding actions and learnings. DON completes a 6 monthly audit on all complaints received form all 3 wards and nursing administration with outcomes, learnings and actions discussed with ADON and CNMs and regular CNM meetings.

Complaints review officer training cert and record is up to date and retained on site.

Action complete.

Regulation 17: Premises	Not Compliant

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

• The upgrade and repair of the roof in the centre involves a major scope of works and the project continues to progress. The project is divided into 3 phases with phase 1 completed April 2026. Phase 2 is currently at tender stage with a tender return date of July 20th 2026 and a design team to assess the project by 31/07/2026 and contractor

appointed in early August 2026. Phase 2 encompasses all resident areas including area above resident's bedrooms and communal spaces and projected time line for completion of phase 2 is Dec 2026. The 3rd phase encompasses the front of the building, administration section and will commence early 2027 and expected date of completion is Q2 2027. – Planned completion July 2027

• As a result of the roof repair works, a programme of repair and maintenance has been initiated. Issues including damaged doorframes, scuffed walls and ceiling defects have been logged and are being addressed under the centre's maintenance plan. Painting will commence in July 2026 in the areas where roof repairs have been completed with further areas being addressed as roof repairs progress.
• The remaining issues with flooring, painting and cabinetry works will take place upon completion of the roof repair works to include the activity kitchen works. These works will coincide with the roof upgrade.
• Initial remedial works for internal courtyards will be completed by December 2026 with a full review and replacement of the paving surface, sitting areas and appropriate planting to take place. Expected Date of completion December 2026.

• A review of residents sinks has taken place and plugs will now be provided in line with regulation and in line for completion on 7th August 2026.

• Doorbell type call bells will be changed over to a new system with a display screen in each unit and activation of call bell will continue to sound until assistance arrives. This will also include the outdoor areas. Costings are currently being drawn up and expected date of completion is September 2026. Risk assessment in place for current system. – Planned Completion September 2026

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

All residents that are transferred to the acute services have a National transfer document completed and a copy is retained in their file. All documentation that supports a residents transfer is maintained in their file. CNM on each unit has oversight of residents transfer to the acute services supported by the ADON.
A new check list has been included on the safety pause to ensure compliance with Regulation 25.

Action complete.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• A full conditional report has been carried out by Titan Fire Safety. Works are well underway and are expected to be completed on the 30th August 2026
• The HSE carpenter has been repairing and upgrading doors one day a week for the last 3 months. New fire door assemblies have been delivered for the commercial Kitchen and are programmed to be fitted at completed by end of July 2026.
• Directional signage directing patrons to the enclosed room or enclosed inner court yard area will be removed and will be actioned by 30th August in line with the current EEL electrical upgrade.
• The narrow fire exit door will be changed over to a double door to accommodate bed evacuation and projected completion date is October 2026. Currently there are 7 Fire Wardens onsite, 2 in each unit who promote fire safety awareness and the identification and management of fire risks embedding a fire safety culture within the service and ensuring continual improvement in all aspects of fire safety. All staff are aware of the limitations of the narrow door in fire evacuation which can be used for mobile and wheelchair dependent residents with risk assessment in place. Bed evacuations can be facilitated through to alternative exits within a safe evacuation time as evident in fire drills.
• Fire Evacuation training and fire safety training will be provided by our external HSE training provider. This training will ensure confirmation of learning. Awaiting dates from the external fire safety training provider. Fire drill documentation reviewed and updated to reflect compartment evacuation and full evacuation.

• Our HSE CPD accredited Vertical emergency evacuation instructors will deliver further training Ski sheet training. Planned training dates for August and September 2026. The aim is to reach 100% trained staff by December 2026. All staff to receive the fire safety strategy document for Sacred Heart. All staff to complete HSE fire safety mandatory training on the HSE Land platform as soon as reasonably practicable to ensure the 100% goal. Currently 97% of staff have completed HSEland fire training. Weekly ski sheet check list is in place in all units. Action completed.

• Cupboard doors enclosing electrical infrastructure have been upgraded with fire rated door closure and smoke detection and are fire stopped with fire doors. Action completed. All remaining cupboards have been reviewed and storage removed from non-fire rated presses. Globally harmonised hazard warning Symbols will be affixed to hazard areas including Electrical, Chemical, Gas, etc. A fire safety assessment has been requested and awaiting date confirmation. Proposed completing before end of Quarter Four 2026.

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

Each resident has an individualized plan of care commenced on admission and reviewed and updated as required. Wound audit is completed 6 monthly and this has now increased to quarterly to improve the efficacy of wound care plans with ongoing education and training facilitated by wound care resource nurse which includes pain management and wound care. A repeat audit will be carried out in September 2026 following education and training sessions.

A safeguarding workshop was held in SHH on the 10 June 2026 encompassing person centred safeguarding care planning. Making safeguarding personal will be introduced to all units with a focus on person centre care plan commencing in July 2026 to include staff education and a re-audit of care plans in September 2026.

Expected date of completion September 2026.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
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.	Not Compliant	Orange	31/07/2027
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/07/2027
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge	Substantially Compliant	Yellow	03/07/2026

	of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
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.	Not Compliant	Orange	31/12/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/12/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire	Substantially Compliant	Yellow	31/12/2026

	alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2026
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Substantially Compliant	Yellow	03/07/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/09/2026