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:	Cobh Community Hospital
Name of provider:	Cobh Community Hospital
Address of centre:	Aileen Terrace, Cobh, Cork
Type of inspection:	Unannounced
Date of inspection:	01 April 2026
Centre ID:	OSV-0000558
Fieldwork ID:	MON-0048575

About the designated centre

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

Cobh Community Hospital was established in 1908. It is run by a voluntary Board of Management and cares for 44 older adults. The "Friends of Cobh Hospital" are involved in fund raising for the hospital. Medical care is provided by a team of local doctors and a pharmacist is available to residents and staff. The older and main part of the hospital is laid out over three floor levels. The ground floor is split into two levels with the upper level accessible via a platform type lift or by a stairs consisting of six steps. Bedroom accommodation on the ground floor comprised four single bedrooms and two twin bedrooms. Bedroom accommodation on the upper level of the ground floor comprises one single en-suite bedroom and one four-bedded en-suite room. Bedroom accommodation on the first floor comprises three single bedrooms, four twin bedrooms and two four-bedded rooms. A new extension accessible through a corridor consists of 12 single en- suite bedrooms. The second floor is used primarily as office space. The first and second floors are accessible by a lift and stairs. Communal space available to residents comprises a large day room with dining tables and chairs, a separate dining room on Bluebell, conservatory, quiet reflection room, a quiet relaxation room called 'The Snug'. Outdoor spaces include a large mature sensory garden, a balcony area off the dining room on Bluebell and courtyard by the conservatory. The centre provides 24hrs nursing care to long and short stay residents, of all dependency levels.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	37

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
Wednesday 1 April 2026	08:30hrs to 18:00hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over one day in Cobh Community Hospital. Overall, residents appeared relaxed in their surroundings. The inspector met many of the residents on inspection and spoke with nine residents in more detail to gain insight into their lived experience in the centre. Residents gave positive feedback about the centre and were complimentary about the care provided, and the friendliness and kindness of staff. Three residents spoken with said they would love additional personal storage space as they only had a single wardrobe for their clothes. Another resident, living in a shared bedroom, said they would love their own television.

Cobh Community Hospital is located in the town of Cobh and is registered to accommodate 44 residents (22 long-stay residential care, and 22 short-stay respite and convalescence care). On arrival to the centre, the inspector completed the risk management procedure of identification check, signing in and hand hygiene.

The suggestion box, registration certificate, advocacy and complaints information were displayed in the main hallway along with other reading material such as the residents' guide, statement of purpose, previous inspection reports, and health and safety statement; the defibrillator is located here.

The building is laid out over two floors and a mezzanine level. Bedroom accommodation comprises single, twin and multi-occupancy four-bedded rooms. Some bedrooms were seen to be personalised. Some residents had access to double wardrobe personal storage space and others had a single wardrobe. While residents had a locker, some were inaccessible to residents from their bed as they were located at the far side of the room. Some residents did not have access to a television (TV) in their bedroom. Privacy screens in bedrooms were heavy, cumbersome and had several brakes to be released so they could not be used independently by residents.

There was directional signage to inform residents of rooms such as the Rose Café dining room for example, to help minimise disorientation. Communal rooms comprise a large day room with dining tables, arm chairs, and a kitchenette; there is a separate dining room on Bluebell; the reflection room and a quiet room called 'The Snug' are located on the main corridor. Previously, the hairdressers' room was part of the nurses' office, this office was reconfigured and the room is now solely used as a nurses' office. The hairdressers' sink was relocated to The Snug and is discretely stored underneath a mobile press. This press is removed when the hairdresser visits and the setting facilities a lovely relaxing venue for residents' to sit and chat while waiting for their hair to be up-styled; residents reported that they loved the new set-up.

The inspector spoke with the activities co-ordinator who outlined the activities programme. This varied from 1:1 individualised sessions with residents in their bedrooms, small group activities as well as larger group activities. The activities programme displayed detailed massage, manicures, nail therapy, music, quiz, knitting, art, and music for example. Residents were seen to enjoy the activities and staff interaction throughout the day. The local community is very involved in the life of Cobh Community Hospital and volunteers were on site during the morning of the inspection and assisted with activities in the main day room.

Residents had access to a variety of outdoor spaces such as the larger mature sensory garden with walkways and seating, a smaller patio area outside a conservatory, and a balcony which could be accessed from the dining room on Bluebell. One resident spoken with was sitting outside on the balcony; they bring out their radio and listen to the local channel. They explained to the inspector the sights seen from the balcony, such as the Cathedral, their old school and the beautiful views of the harbour. Raised flowed beds were being prepared for summer bedding plants here.

Serving of the main meal of the day commenced at 12:30hrs with soup offered to residents, which was followed by dinner and then dessert. The desserts were cold options (jelly, ice-cream and mouse) however, these were seen to melt before being served as they were brought to the dining room early. Meals looked appetising and residents reported that the quality of food was good and there was good choice. Residents were assisted in accordance with their needs, and staff were seen to actively engage with residents. The dining areas enabled social interaction between residents, for example, one large table could seat eight residents comfortably, and residents were observed to meet up with their friends, chat and catch up. Snacks and drinks were offered to residents throughout the day. Later, tea was served at 16:30hrs.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), as well as to inform the renewal of registration process following receipt of an application by the registered provider.

Findings of this inspection were that further action was required by the registered provider to improve the oversight of the service. Management systems in place to identify and monitor the quality and safety of care provided to residents required improvement. While a schedule of audit was in place for 2026, with different staff

completing these audits, many did not accurately reflect the service as it is to enable quality improvement; this is further discussed under Regulation 23: Governance and Management.

Actions from the previous inspection that were addressed included general storage, installment of a ramp access to the balcony in Bluebell, water temperatures adjusted to ensure people's safety, removal of obsolete fire signage, the addition of fire safety equipment as part of the smoking shelter, and the removal of personal information regarding residents' nutritional needs in Bluebell dining room; improvement was noted in some aspects of residents' care records, and aspects of the premises. Issues identified on the previous inspection, not actioned, included wound care, personal emergency evacuation plans (PEEPs) for residents, complaints records, directory of residents, Schedule 5 policies and procedures, residents' access to bedside lockers and very limited personal storage space for their clothing, and infection prevention and control, to ensure the safety and welfare of residents and staff, and quality of life of residents. Many of the findings on this inspection were repeat findings, and these are reported on under the relevant regulations.

Cobh Community Hospital is a voluntary hospital, managed by a board of directors. One of the members of the board represents the registered provider (Cobh Community Hospital) for the purposes of regulation and registration. The management structure on site comprises the person in charge, assistant person in charge and two clinical nurse managers. The management team is supported by a team of nurses, health-care assistants, catering, household, administration, maintenance and volunteers. There were 37 residents in the centre on the day of inspection.

The statement of purpose and floor plans were examined and they required updating to ensure regulatory compliance and registration renewal requirements. While Schedule 5 policies and procedures were available, some were not updated to reflect changes to legislation. This is further discussed under Regulation 4: Policies and procedures.

The staffing roster was examined, and while there were adequate staff and skill mix throughout the day, a review of twilight hours was requested to ensure adequate support and supervision during late evening times. Mandatory training and other training relevant to roles and responsibilities was provided for staff; this was up to date and there was good oversight of training needs and refresher training.

Records were readily available to the inspector. A sample of complaints records were reviewed; while some information was included in these records, it was very limited and required attention to ensure the specified regulatory requirements were recorded; these are further discussed under Regulation 34: Complaints procedure.

Registration Regulation 4: Application for registration or renewal of registration

An application to renew registration of Cobh Community Hospital was submitted along with the associated documentation of floor plans and the statement of purpose. Associated fees were paid to the regulator.

Judgment: Compliant

Regulation 14: Persons in charge

There is a person in charge in Cobh Community Hospital. They worked full time in the centre. They held the required management experience and qualifications and were aware of their responsibilities under the regulations.

Judgment: Compliant

Regulation 15: Staffing

Cognisant of the size and layout of the centre, a review of twilight hours was required to ensure adequate support and supervision during late evening times, as staffing on each of the three units from 8pm – 8am comprised:

- RN x 1 and HCA x 1.

Medication rounds on each unit commence following staff handover at 8pm, so the nurse is occupied with medication administration for some time. Consequently, HCAs are responsible for supervision of residents, comfort rounds with the possibility of residents requesting to go to bed. Currently, there are approximately 20 residents assessed as high to maximum dependency with many requiring two staff to provide assistance. One HCA on their own would be unable to provide the necessary assistance to all residents on their units.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provide ensured that staff had access to mandatory and other training pertinent to their roles. Mandatory training was up to date for all staff. Training was scheduled for the weeks following the inspection for care planning documentation, manual handling, fire safety, infection control, falls prevention, end of life care, responsive behaviours and restrictive practice for example, to ensure training remained current.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents required updating to ensure regulatory compliance with the requirements of Schedule 3 as follows [repeat finding]:

- time and cause of death
- date residents are temporarily transferred to another care facility.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems in place required action to ensure the service is safe, appropriate, consistent and effectively monitored:

- many of the deficits identified on the previous inspection of May 2025 were not addressed, despite a compliance plan from the provider saying they were completed. These are highlighted in this report as repeat findings
- audits did not reflected accurately the premises and how it impacted residents' quality of life, for example, cumbersome privacy screens in multi-occupancy bedrooms were not identified as impeding residents' ability to maintain their independence, privacy and dignity; the layout of some bedrooms did not facilitate adequate personal storage space; other inspection findings were not identified, such as deficits in fire safety precautions [as detailed under Regulation 28: Fire precautions],
- the mandated infection prevention and control national standards had not been implemented into practice, as detailed under Regulation 27: Infection control [repeat finding]; some of these deficits were not identified in the associated IPC audit,
- there was a lack of oversight of complaints management to ensure concerns raised would be timely and appropriately addressed [repeat finding]; and not identified as part of the auditing process,
- there was a lack of oversight of fire safety precautions [repeat finding]
- there was a lack of oversight of Schedule 5 policies and procedures as some were not in place and another was not updated in accordance with specified regulatory requirements,
- deficits in oversight of risk management, for example, large store presses by nurses' station on Bluebell was unsecured and contained lots of clinical equipment; the medication room containing an array of medications was not secure, enabling easy access to these products.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to ensure compliance with Schedule 1 of the regulations, as follows:

- the organisational structure did not include the registered provider
- staffing regarding whole-time equivalents (WTEs) for HCAs, MTAs and activities personnel was not clear
- the complaints procedure was not fully outlined
- there was no information relating to maintaining the privacy and dignity of residents
- description of the rooms in the centre including their size and primary function was not clearly outlined.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the accident and incident log showed that the associated notifications were submitted to the regulator.

Judgment: Compliant

Regulation 34: Complaints procedure

Action was required to ensure complaints were recorded and managed in accordance with specified regulatory requirements, as follows [repeat finding]:

- complaints, actions taken on foot of a complaint, and outcomes of complaints were not fully and properly recorded
- it could not be determined from the complaints' records if complaints were managed within the specified time-lines as the records seen were incomplete, this also including reviews,
- the complaints procedure displayed did not have the necessary information to inform people on how to make a complaint, in accordance with specified regulatory requirements

- while the statement of purpose detailed that residents had access to Patient Advocacy Services [PAS], there was no information displayed or referenced in relevant literature such as the complaints procedure regarding PAS.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Action was required to ensure Schedule 5 policies and procedures were available, and were updated in accordance with best practice, [repeat finding]:

- while the HSE national policy relating to safeguarding was in place, a centre specific addendum was not, to outline procedures specific to Cobh Community Hospital, including their safeguarding officer, and contact details for local HSE supports and PAS for example,
- a policy relating to 'Responding to Emergencies' was not available
- the policy relating to risk management was not updated to reflect the changes to legislation in April 2025.

Judgment: Substantially compliant

Quality and safety

Staff were respectful and it was evident that the team knew residents well and were observed to actively engage with residents throughout the inspection.

Residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as physiotherapy, dietitian and speech and language, as required. A sample of end of life care plans were examined and these demonstrated good insight into residents' wishes, preferences and decisions made about their care. Good oversight of residents' nutritional needs were evidenced with a weight analysis over the previous six months, with additional information showing timely referrals and actions taken to address residents' needs. The sample of care plan documentation was reviewed; while some improvement was noted regarding assessment and care planning process, deficits were identified, to enable and ensure individualised care. Wound care management records seen did not reflect a high standard of nursing care as there were no associated assessments or care plans for the related wounds to enable best outcomes for residents. These are further discussed under Regulation 5: Individual assessment and care plan, and Regulation 6: Health care, respectively.

Regarding fire safety, the inspector reviewed fire safety management; issues identified on the previous inspection that impacted residents' safety had not been actioned. Further concerns were identified on this inspection as detailed under Regulation 28: Fire precautions. The provider representative acknowledged these concerns, and person in charge committed to undertaking simulated evacuations to be assured that these could be done in a timely and safe manner. Associated reports were submitted to the regulator following the inspection with a commitment that these would be undertaken on a weekly basis until such time as they were assured of the process.

'Friends of Cobh Community Hospital' supported the service with funding and community support along with volunteers. Volunteers were on site during the inspection and were seen to positively contribute to the activities programme in the main day room. The inspector found that while residents' right and choices were promoted, some issues were identified relating to their personal storage space and access to personal possessions which impacted their quality of life, and these are discussed under the relevant regulations.

Regulation 12: Personal possessions

Action was required to ensure residents retained control over their personal property and possessions [repeat finding]:

- some residents had access to only a single wardrobe to store their clothing such as hanging dresses, trousers, blouses and shirts; a single wardrobe is inadequate for people living in long-stay residential care,
- because of the layout of some twin occupancy bedrooms, residents did not have access to their bedside locker as it was located at the far side of their bedroom; lockers were seen to store their clock, toiletries, cosmetics, biscuits and water for example, which residents would have a reasonable expectation of having easy access to these.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Action was required regarding food and nutrition as follows:

- while some food items stored in fridges and freezers were dated and labelled, others were not, to be assured that food was maintained in accordance with HACCP guidelines and could be prepared safely
- cold deserts were not served appropriately as jelly and ice-cream was seen to have melted when served to residents.

Judgment: Substantially compliant

Regulation 27: Infection control

Action was required to ensure that mandated infection prevention and control procedures consistent with the standards published by the Authority were in place and implemented by staff, as:

- sharps bins were open and not covered when not in use as required by professional guidelines [repeat finding]
- some clinical hand wash sinks were not compliant with current guidelines of HBN-10 as there was a metal outlet and this outlet was directly below the water flow [repeat finding]
- the water outlets of some handwash sinks were seen to be visibly unclean [repeat finding]
- there was no handwash sink in the household cleaners' room
- there were two identical stainless steel sinks in the sluice room on Daffodil, however, neither were identifed as a hand wash sink; there were bedpan insets left in one of the sinks awaiting cleaning
- two of the new clinical handwash sinks were very stained
- items such as incontinence wear, used beakers and a jug were left on the window sill along one corridor on Daffodil.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The following required attention to ensure compliance with fire safety precautions as follows:

- residents had Personal Emergency Evacuation Plans (PEEPs) in place, however, they did not routinely detail the evacuations supports residents required for both night and day time evacuations [repeat finding]
- some of the information contained within the PEEPs was conflicting, for example, a resident required wheelchair assistance for long distances, yet the evacuation plan detailed they would be able to walk in the event of an emergency evacuation
- emergency evacuation floor plans were displayed throughout the building, however, in general, they were not orientated to reflect their relative position in the centre so could be confusing when following an evacuation route [repeat finding]
- daily fire safety checks were usually completed Monday – Friday, however, these checks were not completed at weekends; some of the daily checks had

not been completed in the weeks prior to the inspection; this deficit was not identified as part of the auditing process,
- simulated evacuations were only undertaken by training personnel. Two simulated evacuations were completed in February and March 2025, and none undertaken since then, so it could not be assured that residents could be evacuated in a safe and timely manner. Included in the feedback seen in these training reports, the trainer recommended additional practice sessions to ensure evacuation drills could be completed in a timely and safe manner, however, these was not undertaken.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required regarding residents assessments and care planning documentation, as follows:

- one resident's care documentation reported that they had multiple wounds, however, the associated wound care management records such as assessments, status update, or wound care regime were not in place to enable assessment and ensure treatment was effective
- the significant medical history of one resident did not inform their assessment or care plan to enable the resident to be cared for in accordance with their medical needs and to recognise deterioration in their well-being.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical and allied health services, and specialist services such as palliative care and gerontology for example.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure all residents had access to their own television, as:

- there was just one television in twin bedrooms, consequently, some residents did not have access to a television in accordance with their stated wishes.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cobh Community Hospital OSV-0000558

Inspection ID: MON-0048575

Date of inspection: 01/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To begin with, we will look to see if one of the nursing shifts could be adjusted to be 09.00 – 21.00 to cover the deficit noted. The CNM2 assists between 08.00 - 9.00 to fill that gap. If this is not achievable, we will look at the possibility of an HCA shift adjusting to be 09.00 – 21.00. If neither of these plans is feasible, we will consider implementing a specific twilight shift to cover the time identified by the inspector. Responsible Person: Director of Nursing: Colin Harris	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: An up-to-date directory of residents containing all information required by the Regulations will be maintained. Ensuring to include time and cause of death & date residents are temporarily transferred. Post-inspection, the Excel directory has been updated with the required resident data. In addition, the Epic system generates a comprehensive resident directory with all required details, used alongside the Excel file for full compliance. Both systems will be regularly reconciled and available for review. Ongoing monitoring will verify accuracy with admissions, transfers, and discharges.	

Regulation 23: Governance and management	Not Compliant

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

The governance and management of Cobh CH will be reviewed and improved. This will be done in a number of different ways.

Monthly governance meetings with the hospital management teams, including CNMs, ADON, Kitchen, and Cleaning managers, will have an action log that will be monitored by the DON. In this log will be tasks to be completed, quality improvement initiatives that are in progress, and items for HIQA. These actions will have named managers responsible for completing and specific timelines, which will be overseen by the DON.
Responsible Person: Director of Nursing: Colin Harris

A full review of all repeat findings from the previous inspection will be completed to ensure actions reported as completed are fully implemented and evidenced in practice.
A post-HIQA visit task board will be reviewed and available to all in the management team so that any items raised on the last inspection have been rectified. This will regularly be reviewed by the DON and ADON until all tasks have been completed.
Responsible Persons: Director of Nursing: Colin Harris & Assistant Director of Nursing: Collette O'Toole.

Governance will be strengthened through a better oversight structure. This will include better accountability and reviews, named individuals being assigned, and this will be reviewed and followed up within the line management structure. The use and encouragement of resident feedback to influence their care and their living environment will take place through monthly meetings, feedback leaflets and direct conversations with them by staff and management. Resident meetings will occasionally include guest speakers, ranging from the DON to the OT.

The use of SMART goals and PDSA cycles for implementing new quality improvement initiatives, or for addressing any failings. Monthly staff forms will be held, these will include a representative from each of the staff groups, HCA, RGN, Cleaning and kitchen. These will be held by the director of nursing and provide staff with a direct outlet to convey any concerns or suggestions they may have. It will also be important to highlight the good at these meetings; they will be minuted and available to all staff. The quarterly staff meetings will continue to take place.

The risk register will be used to highlight any risks or areas where improvement is limited, identifying the risks and all actions to minimise their impact. A more visible management presence will be implemented, allowing residents to stop and discuss any items they may wish with the team, as some people prefer one-on-one, face-to-face conversations to feedback forms or meetings. This will also help instil in residents a

sense of confidence that the management team is visible and accessible. Responsible Persons: Director of Nursing: Colin Harris

With the assistance of the Assistant Director of Nursing: Collette O'Toole.

Audit systems will be revised to better reflect residents' lived experience and the actual conditions in the centre, including privacy, dignity, independence, storage, fire safety, infection prevention and control, complaints management, and the implementation of Schedule 5 policies. We have reviewed the Audit system. We have moved our Audits to the Epic system rather than the paper-based system that was available on the day of inspection. The wording of questions will be adjusted and made more relevant to Cobh CH. Audits will be made more responsive and outcome-focused so that identified risks and service deficits are promptly escalated, addressed, and re-audited.
The use of the QUIZ tool will also be better implemented to have a recorded sense of the resident's experience, while dining, at activities or to assess the passive resident experience (sounds, smells etc..) of the unit. Responsible Persons: Assistant Director of Nursing: Collette O'Toole & Director of Nursing: Colin Harris. Clinical Nurse Manager 2 Aileen Ryan and Clinical Nurse Manager 2 Margaret McNamara are primarily responsible for QUIZ.

The director of nursing will also be involved in the QUIZ.

Oversight of fire precautions, infection prevention and control, complaints management, policy review, and risk management will be strengthened through clearer lines of accountability and regular management review and updated audits. This will include ensuring that unsecured clinical stores, medication rooms, and other environmental or operational risks are identified through the risk management and audit process and acted on without delay. Responsible Persons: Director of Nursing: Colin Harris& Assistant Director of Nursing: Collette O'Toole. Clinical Nurse Manager 2 Aileen Ryan and Clinical Nurse Manager 2 Margaret McNamara will monitor day to day unsecured rooms and the environment.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
We will review and update the statement of purpose to ensure it contains all information required under Regulation 3. The organizational structure has been amended to include the registered provider and clearly show reporting relationships within the center. Staffing details will also be revised so that whole-time equivalent numbers for HCAs, MTAs, and activities staff are clearly set out. The complaints procedure section has been expanded to fully outline how complaints can be made and managed. Information on how the service maintains residents' privacy and dignity has also been added. The

description of the premises will be updated to clearly identify the rooms in the centre, including their size and primary function, so that the statement of purpose corresponds accurately with the layout and operation of the designated centre. The statement of purpose was updated with the recommendations given by the HIQA inspector.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Cobh Community Hospital will review the complaints management system to ensure all complaints are recorded, managed, reviewed in line with the regulations. Responsible Person. Colin Harris, Director of Nursing.

The complaints register and related documentation will be revised to ensure each complaint, the action taken, the outcome, and any review undertaken are fully and accurately recorded. Recording systems will also be updated to clearly show that complaints are managed within the required timelines and that any delays are documented and addressed. Responsible Person. Colin Harris, Director of Nursing.

The complaints procedure displayed in the center will be updated to include all required information on how to make a complaint, how to request a review, and who is responsible for managing complaints and reviews. Responsible Persons: Louise Jordan: Complaints officer. Overseen by Colin Harris, DON.

The PIC will also ensure that information on the Patient Advocacy Service is clearly referenced in the complaints procedure and displayed in relevant information for residents and families. Responsible Person. Colin Harris, Director of Nursing.

Patient Advocacy Service information will be readily available to all residents. Responsible Person. Colin Harris, Director of Nursing.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
A centre-specific additional document to the HSE national safeguarding policy has been developed for Cobh Community Hospital, outlining local procedures, the designated

safeguarding officer, contact details for local HSE supports, and Patient Advocacy Service information and is now in place.
A policy on 'Responding to Emergencies' will be created to ensure staff have clear guidance on emergency response arrangements specific to the centre.
The risk management policy will be reviewed and updated to reflect legislative changes introduced in April 2025, ensuring it supports effective identification, assessment, and mitigation of risks within the service.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Bedroom storage arrangements will be reviewed to ensure residents have adequate, accessible space for clothing and personal belongings in line with their needs and with the expectations of long-stay residential care. Bedrooms where residents currently have access to only a single wardrobe will be reviewed to determine what additional storage can be provided for clothing and personal items, this will most probably be the addition of double wardrobes. The layout of twin bedrooms will also be reviewed to ensure each resident can easily access their bedside locker and the personal items stored within it, such as toiletries, clocks, drinks, and snacks. Where lockers are not readily accessible due to room configuration, furniture placement will be adjusted or alternative arrangements put in place to support residents' independence and convenience.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
All food items stored in fridges and freezers will be reviewed to ensure they are consistently dated and labelled in line with local HACCP procedures. Responsible Person: Kitchen Manager: Sharon Murphy

Staff will be reminded of food safety requirements, and monitoring checks will be strengthened to ensure food can be safely identified, rotated, and used within the appropriate timeframe. Responsible Person: Kitchen Manager: Sharon Murphy.

Cold desserts will be reviewed as part of the mealtime service process to ensure they are served at an appropriate temperature and in a suitable condition for residents. Serving

practices will be monitored so that items such as jelly and ice cream are presented safely and palatably at the point of service. Responsible Person: Kitchen Manager: Sharon Murphy for informing staff working in the kitchen, pantry and observing practice. Clinical Nurse Manager 2 Aileen Ryan and Clinical Nurse Manager 2 Margaret McNamara will be responsible for monitoring meal times and educating staff on the expected standard for cold desserts.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Sharps management practices will be reviewed to ensure sharps bins are closed and secured when not in use. Staff will be reminded of correct sharps disposal practices, and compliance will be monitored through regular checks and audits. Responsible Persons: The CNM2s, Margaret and Aileen, will discuss this with the nursing staff at Safety pause and will continually review practice on the wards. Assistant director of Nursing: Collette O'Toole will audit.

All clinical hand wash sinks will be reviewed to assess compliance with current HBN 00-10 guidance, including sink design, outlet position, cleanliness, and suitability for use. A risk assessment and remedial action plan will be completed for non-compliant sinks, and staining or poor hygiene at sinks will be addressed without delay. Responsible Persons: Maintenance Manager: Toddy Stafford, Cleaning Manager: Ann Lane. Overseen by Director of Nursing: Colin Harris

The availability and identification of hand hygiene facilities will be reviewed throughout the centre, including the household cleaners' room and the sluice room on Bluebell the hand wash sinks will be clearly designated for hand hygiene only, and inappropriate use or storage of items in these areas will cease immediately. Responsible Persons: Maintenance Manager: Toddy Stafford.
The CNM2s, Margaret and Aileen will address incorrect storage.

Items being left on windowsills during the inspection indicate poor infection control practices; this will need to be addressed by all staff members. The CNM2s will highlight to the Nurses and HCAs why this practice is unacceptable and not in line with best practice for infection control. They will also monitor compliance on the units daily to ensure items are not placed incorrectly. The infection control nurse will conduct Audits of clinical areas to identify poor practices, and this feedback will be made available to all staff. This will all be overseen by the Director of Nursing and Assistant Director of Nursing through regular reviews of the units and direct questioning of staff when

incorrect practices are found, with a focus on education. Responsible Persons: CNM2s, Margaret and Aileen (Day to Day environment). Infection Control Nurse: Aine Murly (Audits). Director of Nursing: Colin Harris
Assistant Director of Nursing: Collette O'Toole (Overseeing and correcting poor practices).

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PEEPS have been updated after the inspection, and they have been redesigned from scratch. They now clearly include evacuation supports for day and night and are more person-centred.
The PEEPs will be audited by the Assistant Director of Nursing. Responsible Persons: CNM2 Margaret McNamara created and implemented the new PEEPs. Assistant Director of Nursing. Overseen by DON.

The Director of Nursing has since attended additional training on Fire Safety for PICS. This was to strengthen the overall governance of fire safety in Cobh Hospital through education and the application of the legislative items covered in the course. Responsible Person: Director of Nursing: Colin Harris

The floor plans are being updated to show some items that were missing on the last inspection (Showers, sinks etc...). When they are placed on the walls again, they are to be oriented to the direction the person is looking and with clear indications of evacuation routes. Responsible Person: Director of Nursing: Colin Harris

The oversight on the daily fire checks has been addressed, and this now takes place 7 days a week. This will be part of our Fire Audit to ensure continued compliance. Responsible Persons: Assistant Director of Nursing: Collette O'Toole. Overseen by DON.
The evacuations have been reviewed since the inspection, and more regular simulated evacuations with an updated record sheet have been carried out. Responsible Persons: Assistant Director of Nursing: Collette O'Toole. Overseen by DON.

To address governance failings in fire at Cobh CH, quarterly and ad hoc audits will be conducted to highlight any outstanding items prior to an inspection, so the management team can address and rectify them. Responsible Persons: Director of Nursing: Colin Harris & Assistant Director of Nursing: Collette O'Toole.

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:
It will be ensured that each resident's assessment and care plan accurately reflects their current needs, guides care delivery, and supports the timely recognition of deterioration in health and wellbeing. The care plan for the resident with multiple wounds will be reviewed immediately to ensure a full wound assessment, ongoing status updates, and a clear wound care regime are in place to guide treatment and monitor effectiveness. Accurate wound records are necessary to show progress, support clinical decision-making, and ensure consistent care delivery. The assessment and care plan for the resident with a significant medical history will also be reviewed and updated so that their known diagnoses, associated risks, and required observations clearly inform their care. This will support staff to deliver care in line with the resident's medical needs and to identify any deterioration in a timely manner. The CNM2s will be conducting audits of a minimum of three care plans each month to ensure they are compliant.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
We will review bedroom arrangements to ensure that residents in twin rooms each have access to a television. Each twin room will have two televisions going forward.
Responsible Persons: Toddy Stafford: Facilities manager for the procurement of the TVS and installation. Colin Harris, Director of Nursing, to ensure that the actions have been completed in a timely fashion.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	01/06/2026
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	01/06/2026

	and other personal possessions.			
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.	Substantially Compliant	Yellow	01/07/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	27/04/2026
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	27/04/2026
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.	Not Compliant	Orange	30/07/2026
Regulation 27(a)	The registered provider shall ensure that	Substantially Compliant	Yellow	01/07/2026

	infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.			
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.	Substantially Compliant	Yellow	01/07/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	27/04/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	27/04/2026

Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	17/04/2026
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	27/04/2026
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	17/06/2026
Regulation 34(2)(e)	The registered provider shall ensure that the complaints procedure provides that a review is conducted and	Substantially Compliant	Yellow	14/05/2026

	concluded, as soon as possible and no later than 20 working days after the receipt of the request for review.			
Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.	Substantially Compliant	Yellow	17/06/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and	Not Compliant	Orange	01/07/2026

	distinct from a resident's individual care plan.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	27/04/2026
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	27/04/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	27/04/2026
Regulation 5(3)	The person in charge shall prepare a care	Substantially Compliant	Yellow	29/04/2026

	plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.	Substantially Compliant	Yellow	01/06/2026