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 Castlebar
Name of provider:	Health Service Executive
Address of centre:	Pontoon Road, Castlebar, Mayo
Type of inspection:	Unannounced
Date of inspection:	07 May 2026
Centre ID:	OSV-0005730
Fieldwork ID:	MON-0049656

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 purpose-built facility completed in 2018 that can accommodate 74 residents who require long-term residential care. Care is provided for people with a range of needs: low, medium, high and maximum dependency and people who have dementia or palliative care needs. This centre is a modern two-storey building and is located adjacent to the original Sacred Heart Hospital premises. It is a short drive from shops and business premises in Castlebar. It is comprised of two self-contained units. The Ross unit is located on the ground floor and the Carra unit on the upper floor. There is lift access between floors. There are 35 single rooms and one double room, all with full en-suite facilities, on each floor. The centre has a large safe garden area on the ground floor. This has several access points and was well-cultivated with flowers, trees and shrubs to make it interesting for residents. The philosophy of care as described in the statement of purpose is to use a holistic approach in partnership with residents and their families to meet residents' health and individual needs in a sensitive and caring manner while balancing risk with safety.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	64

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 7 May 2026	09:00hrs to 16:30hrs	Michael Dunne	Lead
Friday 8 May 2026	08:00hrs to 12:45hrs	Michael Dunne	Lead

What residents told us and what inspectors observed

This inspection found that residents experienced a high quality of life, with care delivered in line with their preferences, while promoting their independence and autonomy. Support was provided in a positive and respectful manner by a committed staff team, who demonstrated a clear understanding of the provider's values and care philosophy. This approach ensured care remained person-centred, enabling residents to maintain self-care skills and exercise choice in their daily routines and the services they received.

These findings echoed the feedback from residents and visitors regarding their views on the quality of care provided. Residents told the inspector that they felt safe in the centre, were well-cared for, and that they enjoyed their quality of life in the centre. One resident told the inspector " that they could not praise the staff enough for the care and support provided, and they added that this is a great place to live." The inspector also spoke with visitors attending the centre, and they informed the inspector that the quality of care provided was "a thousand percent".

The Sacred Heart Hospital is a two-storey, purpose-built premises built around a large internal courtyard. The designated centre is located within the Sacred Heart Hospital campus, and comprises of two units, the Ross unit and the Carra unit. At the time of this inspection, there were 64 residents living in the centre. This unannounced inspection was conducted over two days with the inspector focusing on the Ross unit on day one of the inspection, and the Carra unit on day two. Following an introductory meeting with the person in charge and a clinical nurse manager (CNM), the inspector conducted a walk around of the centre, where they had the opportunity to meet with residents and staff as they began their day.

Overall, communal facilities were comfortable and suitable for resident use. Corridors were wide and decorated with murals and pictures of local places of interest that residents would be familiar with. Communal areas were supervised at all times to ensure resident safety. There was a homely feel to the centre, care was taken to decorate communal spaces with ornaments and comfortable seating. However, there were a number of areas of the centre that were now showing signs of wear and tear with scuff damage to walls observed in several areas, including a residents' sitting room.

Several residents were observed relaxing in the sitting and dining rooms on both units. 50% of residents living in the designated centre were supported to attend a Mass service, which was held every Thursday in the church located on the campus. Residents who spoke with the inspector were content that they received this support. There was a variety of social activities observed and facilitated by staff over the two days, including the showing of nature videos, music, sensory support with candles and lights, and one-to-one support for residents who did not wish to engage with group activities. The inspector spent periods of time in the communal areas

throughout the day, and observed that residents were enjoying positive, and therapeutic interactions with staff. On day two of the inspection, the provider installed a large-sized television for the residents in one of the sitting rooms.

The inspector observed that each resident had a functioning call-bell in their bedrooms and observed an improvement in call-bell responses from the last inspection. Resident bedrooms were well presented, suitably furnished and designed to meet individual needs. Each room was equipped with overhead tracking to support hoist use where required. Rooms reviewed were appropriately arranged, including shelving, a lockable cupboard, and a fridge for personal food, and drink storage.

Overall, the centre was clean and maintained for the comfort of the residents. However, a household room on one of the units was unclean with stains on the wall and around the sink area. The floor area was also unclean, while supplies of alcohol hand rub were stored on the sink top. The inspector found some inappropriate storage in the equipment stores and in a sitting room. While the provider made available additional storage outside of the unit, there was inconsistent oversight of storage in one of the store rooms where both clinical and non clinical items were being stored in close proximity to each other. Furthermore, a resident's wheelchair was found stored in a residents' sitting room.

Residents had unrestricted access to all areas of their home, including access to outside facilities. The communal garden area was well-maintained and well-appointed with flowers, shrubs, and garden furniture. There was adequate seating to cater for the number of residents using this facility. The provider maintained level access throughout the garden area, which facilitated residents using mobility equipment to enjoy this space.

Residents were complimentary about the food served in the centre, and confirmed that they were always offered a choice of menu options. Some residents required additional support with their eating and drinking, and observations confirmed this assistance was provided in a supportive and discreet manner, taking into account the individual needs of each resident. Options available on the day included chicken and rice or a baked ham meal option. Catering staff confirmed that other options were available for residents should they not like what was on the menu.

The next two sections will present an overview of the governance and management capability of the centre and the quality and safety of the service and present the findings under each of the individual regulations assessed.

Capacity and capability

This was a well-managed centre that ensured that residents were provided with good standards of care to meet their assessed needs. For the most part, there were

effective management systems in place, which provided oversight to maintain these standards. The management team were proactive in response to issues identified through audits with a focus on continual improvement. The provider and person in charge had introduced a number of improvements since the previous inspection, and this was reflected in the improvements in compliance that were found on this inspection in relation to staffing. However, some of the actions the provider had committed to take to bring the centre into compliance with Regulations 23: Governance and management, Regulation 27: Infection control, and Regulation 17: Premises remained outstanding, and required additional focus to bring these regulations into full compliance.

This was an unannounced inspection carried out by an inspector of social services over two days to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and to follow up on the actions the registered provider had undertaken following the findings of the last inspection.

The provider of the centre is the Health Service Executive. The person in charge facilitated the inspection, and they were supported in their role by an assistant director of nursing (ADON) and a team of clinical staff, which included clinical nurse managers and staff nurses. The General Manager for Older Persons' Services for the community health area provided management support and guidance. Additional in-house support is provided by a team of health care assistants, household, catering, administration, and maintenance personnel.

The provider had a range of management systems in place to review the service, and this included a schedule of audits to monitor the quality of the service provided. There were a range of both local, and regional management meetings which provided oversight of the services provided. Audits were carried out on a regular basis, and where improvements were identified an action plan was put in place. However, there was inconsistent oversight of records across several regulations, which meant that there was a risk that the provider did not always have up-to-date information available to them when reviewing the service.

Management meetings were held on a regular basis to review the service, and to identify areas that required improvement. The provider had reviewed their staffing structure for one of the units, and the inspector found that the revised allocation of staff ensured that residents were adequately supervised. The inspector reviewed a sample of governance and management documentation, including audit records, meeting minutes, and complaint records.

A review of records found that there were some shortcomings in this oversight process, as not all audits had identified issues found on inspection in relation to storage and the effective monitoring of infection control. This meant that there was no action plan in place to address these issues, and this impacted on the quality of the service provided to residents. In addition, the oversight of several care records required additional focus to ensure that all records were accurate and up-to-date. While there was a quality and safety review for 2024, the review for 2025 had not

been fully completed and this meant the inspector was unable to review the provider's quality improvement plan of the service for 2026.

There were sufficient numbers of staff on duty on the day of the inspection to meet the needs of residents and to support residents to spend their day as they wished. Staff demonstrated accountability for their work, and were clear about their roles and responsibilities when they were speaking with the inspectors. Staff worked well together to ensure residents needs, and requests for support were met in a timely manner. Staff were observed greeting residents they met in the centre, calling them by their preferred name, and engaging in meaningful conversation. All of the interactions observed were empathetic and respectful. This helped to create a welcoming and pleasant atmosphere for residents and visitors.

There were effective supports in place for staff to attend regular training to enable them to perform their duties to a high standard, and ensure positive outcomes for the residents, although the oversight of training requirements for catering staff was not sufficient. During the inspection, staff discussed their training programme with the inspector and described how training informed their day-to-day work practice. Clinical staff were seen to attend a range of training to maintain their professional competence. For example, training was in place to support medication management, wound care, falls prevention, and catheterisation training.

A review of the complaints records confirmed that the provider was managing complaints in line with their complaints policy. There was effective oversight of complaints with corrective action taken to resolve issues that impacted on the quality of the service.

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill-mix to meet the assessed needs of the residents in the designated centre. A review of the rosters confirmed that staff numbers were consistent with those set out in the centre's statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

From a review of the records and from speaking with staff, the inspector found that overall, staff had good access to training and development opportunities. There were high levels of compliance with mandatory training in safeguarding and fire safety, and moving and handling. Fire safety refresher training was scheduled for

the week after the inspection for those staff who were due updates, and for new staff working in the centre.

There were inconsistent recordings for some staff attending infection control training. A review of records found that catering staff had not completed all the required modules for infection prevention and control as set out in the provider's own training requirements. This finding is discussed under Regulation 27: Infection control.

Judgment: Compliant

Regulation 21: Records

The inspector found that a number of records pertaining to Schedule 1 and Schedule 3 were not well-maintained, for example:

- Residents' care notes did not give sufficient information to support the rationale for when a restrictive practice was introduced for one resident.
- The infection status on one transfer document was not completed for a resident with a known infection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the registered provider had management systems and several levels of oversight in place to monitor the quality of the service provided; however, some actions were required to ensure that these systems were sufficient to ensure the services provided are safe, appropriate and consistent. For example:

- Systems to ensure that residents' care records were updated in accordance with the centre's policies required strengthening as discussed under Regulation 21: Records.
- The oversight of infection prevention and control strategies was diminished due to ineffective monitoring. The system of audit was not identifying a number of infection risks found on this inspection, and as such, action plans to address these risks were not developed.
- The oversight of staff training records did not identify training gaps in infection control.
- The annual review of the service for 2025 had not been fully completed, and as a result the quality improvement plan for 2026 was not available.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place which described the facilities and services available in the centre, and in line with Schedule 1 of the regulations. The statement of purpose made available for review was dated 07 April 2025; however, not all information regarding the service provided was accurate, as it did not include the current laundry arrangements in place, nor did it update the changes of personnel at the provider level.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

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

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

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had ensured that the Schedule 5 policies, and procedures were made available to staff. These policies, and procedures were reviewed and updated within the last three years, and included national best practice guidance, where appropriate.

Staff induction, and ongoing training included Schedule 5 and other relevant policies and procedures. This helped to ensure staff were clear about what was expected of them in their wor,k and the standards that were required to meet.

Judgment: Compliant

Quality and safety

Overall, the quality of care provided to residents was found to be of a good standard, which met the assessed needs of the residents. Staff were knowledgeable about the residents' needs and preferences, with residents reporting that they felt safe and well-cared for by staff in the centre. Although the provider had implemented measures to address sub-compliances found under the previous inspection, further actions were required to bring the centre's premises and infection control and prevention measures into full compliance with the regulations.

The delivery of care and support to residents was based on person-centred principles with residents at the centre of the care planning process. This inspection found that residents' rights were respected, and residents were supported to make decisions regarding their daily lives in the centre. Residents' quality of life was optimised with unrestricted access to all areas of the centre, including the well-maintained garden area. There was a well-planned activity schedule in place, and residents were supported to engage with these activities in line with their interests and capacities.

Overall, residents were provided with good standards of nursing care and had access to timely health care from their general practitioner (GP), who attended the centre on a regular basis. There was also good access for residents to health and social care professional services and psychiatry services, which optimised their health and clinical wellbeing.

The inspector reviewed care records in relation to responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment), and found that care interventions promoted resident safety but also ensured that residents' rights were safeguarded and respected. Records reviewed found that behaviour observation charts were being used to gain an understanding of the behaviour and to identify appropriate interventions. Staff in the centre were seen to have a good relationship with residents who presented with responsive behaviours, and worked in partnership with residents to ensure their care and support needs were met. There were measures in place to review restrictive practices on a regular basis to ensure that they were appropriate and proportionate. While daily progress notes gave a good account of care, and support provided, they lacked sufficient detail to describe, and explain the rationale for when residents were issued with a PRN medication(as required) to ensure that the effectiveness of this intervention was effectively monitored.

Overall, the premises was well-laid out to meet the needs of the residents. The centre was clean and tidy. Communal rooms were comfortably furnished and nicely decorated. Corridors were long, wide, and contained handrails throughout to support residents' mobility. These areas were tastefully furnished, and decorated with murals, pictures of local scenes, and images that residents were familiar with.

By contrast, some areas of the centre were displaying signs of wear and tear, and required decoration to bring these areas up to the standard of the rest of the centre. The relevant areas concerned are discussed under Regulation 17: Premises.

The inspector found that the provider did not fully comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). Repeated weaknesses were identified in infection prevention and control oversight and environmental management. These issues are described in more detail under Regulation 27: Infection control.

There were resident meetings occurring in this centre, which provided residents with the opportunity to give feedback on the service provided. These meetings covered a range of topics that were important to residents, and included items such as catering, activities, and outings. Resident meetings were held every two months, while family forum meetings were held biannually. A quarterly newsletter was available in the centre which was developed with input from the residents living in the centre, and reflected on key events held in the centre and in the wider community.

Residents told the inspector that they enjoyed their meals and that there was plenty of choice on the menus. This was validated by the inspector's observations on the day. There were sufficient staff available at meal times to support residents with their nutritional needs, and residents were supported to eat independently. For those residents who needed additional support at meal times, staff offered discreet assistance in a respectful manner.

Regulation 11: Visits

There were appropriate arrangements in place to ensure residents could meet with their visitors as they wished. Visitors were observed coming and going throughout the day and told the inspectors that they could visit at times to suit them and the resident. There was a visitors' book to sign in, which ensured that staff were aware of who was in the building, and which of the three lodges they were visiting.

Visitors were seen meeting with residents in private areas located around the entrance lounge, as well as with the residents in their bedrooms.

Judgment: Compliant

Regulation 17: Premises

The inspector found that actions were required to ensure the premises met the needs of all residents and that the requirements of Schedule 6 were met in full. For example:

- The walls in a residents' sitting room were damaged and unsightly.
- Walls along a corridor were scuffed and damaged.
- A resident's wheelchair was incorrectly stored in a communal room.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

A review of documentation found that when residents were transferred to the hospital from the designated centre, relevant information was provided to the receiving hospital. Upon residents' return to the designated centre, staff ensured that all relevant clinical information was obtained from the discharging service or hospital. However, the infection status for one resident had not been recorded on the document reviewed, and this is discussed under the records.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy and procedure in place which contained details regarding the identification of risk, the assessment of risk and the measures and controls in place to mitigate against known risks. The policy met all the requirements as set out under Schedule 5 of the regulations.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of the National standards for infection control in the community services (2018). Further action is required to be fully compliant. For example:

- There were gaps in training records to confirm that catering staff had attended infection control training.

- The provider had introduced a tagging system to identify equipment that had been cleaned. However, this system had not been consistently implemented at the time of inspection.

The infection prevention, and control processes that were in place did not adequately address risks associated with the transmission of healthcare-associated infections. For example:

- A storage room on one unit were found to contain a mixture of clinical, and non-clinical items. This increased the risk of cross contamination. For example, Christmas decorations, paper cups, resident mobility equipment, resident slings, and activity supplies were all stored within the same area.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed several residents' care records and spoke with a number of residents on the day. Care records confirmed that the local management team completed a pre-admission assessment for all potential residents to ensure that the centre would be able to meet the person's needs.

All newly admitted residents had a comprehensive assessment of their needs completed when they came to live in the centre. The assessment included potential risks such as skin integrity, falls, personal safety, and the resident's current needs. Nursing staff worked with the resident, and where appropriate, their representative, to develop care plans setting out how the agreed care interventions would meet the resident's assessed needs. Care plans identified residents' self-care abilities, and promoted residents' active involvement in their care. Care plans were reviewed regularly by nursing staff, and were updated as and when resident's care needs changed.

Overall, there was a good standard of care planning in this centre, however daily care notes did not always give a full account of care interventions delivered to the residents, this is discussed in more detail under Regulation 21: Records.

Judgment: Compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre, as required, or requested.

Services, such as physiotherapy, were available to residents weekly, and services such as tissue viability nursing expertise, speech and language, and dietetics were available through a system of referral.

There was evidence that recommendations made by health care professionals were followed up, and monitored. This supported the delivery of care, in line with residents' assessed needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a restrictive practice policy in place to guide staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Records show that when restrictive practices were implemented, a risk assessment was completed and there was a plan in place to guide staff. Alternatives to restrictive practices were trialled. A restrictive practice register was maintained, and was kept under review by the clinical team.

Staff who spoke with inspectors had up-to-date knowledge appropriate to their roles to positively react to responsive behaviours. Staff were knowledgeable on the triggers that may cause residents distress, or anxiety, and were able to use de-escalation techniques to protect residents from harm. Referrals were made to specialist services for advice as, and when required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. Residents were supported to engage in activities that aligned with their interests and capabilities. There was a varied and stimulating activities programme provided seven days a week, and included activities, such as arts and crafts, quizzes, story-telling, bingo, and music sessions. One-to-one sessions also took place to ensure that all residents could engage in suitable activities to align with their interests. Detailed key-to-me assessments were completed, and residents also had life story books completed which aided good communication.

Residents had access to media such as radio, television, and wireless Internet access. Facilities promoted privacy, and service provision was directed by the needs of the residents. There was access to advocacy services as required.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sacred Heart Hospital Castlebar OSV-0005730

Inspection ID: MON-0049656

Date of inspection: 08/05/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: - A digital platform is being introduced which will replace the existing paper-based system. This will ensure effective recording and monitoring of all residents' care associated documentation enabling the staff and management to access up to date information when reviewing the service. - All restrictive practice documentation/ recommendation will be reviewed as part of the ongoing audit review schedule with a view to ensure compliance with current restrictive practice guidelines. - The resident with insufficient documentation regarding the rationale for restrictive practice has been updated. - An emphasis on the importance of correct documentation especially on transfer document regarding infection risks are being communicated to relevant staff via ward meetings, safety pauses, daily handovers and CNM meetings. - With the introduction of the digital platform all IPC alerts will be automatically generated into the transfer document	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: - A digital platform is being introduced which will replace the existing paper-based system. This will ensure effective recording and monitoring of all residents' care associated documentation enabling the staff and management to access up to date information when reviewing the service	

- The new audit schedule which was commenced in March 2026 is now fully operational and all relevant staff who take part in the auditing process are being trained to enable them to audit efficiently.
- The Clinical Nurse Specialist who specializes in Infection Prevention and control has been organized to visit the units to review the issue around storage and also to provide expert advise and additional auditing tools
- A system is now in place to monitor mandatory training compliance which will ensure any gaps will be identified and managed appropriately
- The annual review report for the service for the year of 2025 has now been fully completed and the Quality Improvement Plan for 2026 is in progress

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
- The statement of Purpose has been updated to include the current laundry arrangements in place in the designated centre and also reflect the current management personnel at the provider level

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
- All the areas with wear and tear with scuff damage will be repaired and re painted to ensure the premises met the needs of all residents.
- A maintenance program to be devised which will assure regular monitoring of premises to ensure they are in good condition
- Staff are regularly reminded to not use communal areas for the storage for residents' wheelchairs though ward meetings, safety pauses and daily handovers. The compliance on this is monitored through supervision and spot checks by managers and regular auditing.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: - Immediate corrective actions were undertaken following the inspection, including a review of staff training records, outstanding staff have either completed infection prevention and control training or are scheduled with dates. A system is now in place to monitor mandatory training compliance. - There was reinforcement of the equipment cleaning process; staff have received reminders and refresher education. Compliance is monitored through environmental audits and walk-rounds. Non-compliance is addressed immediately through supervision and spot checks. - The household room has been thoroughly cleaned to include the floors and the walls around the sink area and alcohol hand rub stored appropriately. All household rooms are included in the monthly IPC audit to ensure high standards of cleanliness is maintained. - There was reorganisation of storage areas to ensure appropriate segregation of clinical and non-clinical items. Ongoing monitoring continues through regular environmental audits & walk throughs to include the storage rooms.	

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.	Substantially Compliant	Yellow	30/10/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	23/10/2026
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	Substantially Compliant	Yellow	23/10/2026

	effectively monitored.			
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Substantially Compliant	Yellow	07/08/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	21/08/2026
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	24/07/2026