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:	Youghal Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Cork Hill, Youghal, Cork
Type of inspection:	Unannounced
Date of inspection:	30 July 2026
Centre ID:	OSV-0000577
Fieldwork ID:	MON-0051237

About the designated centre

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

Youghal Community Hospital was built in 1935 and is managed by Health Service Executive (HSE). It is a two storey building with beautiful views out over the sea and river Blackwater. Accommodation is provided for male and female residents in single, twin and a four bedded room. Residents are usually over the age of sixty five, however, care can be provided to an individual under sixty five following a full needs assessment. The maximum number of residents who will be accommodated in the hospital is thirty one. There is 24 hour nursing care provided to all level of dependencies from low to maximum dependency needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	30

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 30 July 2026	07:50hrs to 16:40hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out over one day to monitor the centre's ongoing compliance with the regulations. The inspector also followed up on the actions taken by the provider to address areas of non-compliance found on the inspection of September 2025. Residents living in Youghal Community Hospital spoke positively about their experience of living in the centre and described it as a homely place to live. Residents spoken with, nine in total, told the inspector that they were consistently treated with dignity and respect by staff. They said that staff took time to engage in conversations with them and ensured they were comfortable and well supported. Residents expressed overall satisfaction with the nursing care, healthcare services, and social care provided in the centre. However, a small number of residents reported disappointment that the dining room was not currently open, as they valued the opportunity to dine with and socialise with other residents at mealtimes.

The inspector arrived at the centre early in the morning while the handover between the night and day staff teams was taking place. The inspector observed that a comprehensive discussion was held regarding each resident living in the centre, including their personal preferences, clinical care needs, and current medical status. The person in charge was also present at the handover, and the inspector was informed that a member of the management team attended these handovers on a daily basis to support effective oversight and communication. Youghal Community Hospital is a two storey designated centre for older people situated on Cork Hill in the town of Youghal, East Cork. The building is over 90 years old and lies on an elevated sight with panoramic views of the sea. The centre provides long term and respite care for both male and female adults with a range of dependencies and needs. It can accommodate up to 31 residents, 15 upstairs and 16 downstairs. There were 30 residents living in the centre on the day of this inspection.

Bedroom accommodation comprised nine single bedrooms, nine twin bedrooms and one four-bedded room. Three of these bedrooms had full en-suite facilities, while the majority of bedrooms had access to communal shower and toilet facilities located in close proximity. The inspector observed that residents' bedrooms and communal areas throughout the centre were clean and well maintained. Efforts had also been made to ensure that residents' bedrooms were personalised and homely in appearance. However, improvements were required in relation to storage arrangements within the centre and to ensure that privacy screens were in place around all beds in multi-occupancy bedrooms. These findings are discussed further under Regulation 17.

Communal facilities within the centre were primarily located on the ground floor and consisted of a sitting room, visitors' room, and dining room. On the second floor, there was a small sitting room and a quiet room, each of which could accommodate a maximum of two residents at a time. Staff were observed encouraging residents to

access the ground floor to participate in activities, and a couple of residents were seen using the lift independently.

However, as identified on the previous inspection, the practice of residents remaining in their bedrooms for all meals and not being afforded a communal dining experience continued. On the day of inspection, approximately seven residents were observed having their main meal in the sitting room using a bed table, while all other residents remained in their bedrooms for mealtimes. The dining room was not in use, and residents informed the inspector that it was closed. Discussions with management and staff indicated that the dining room was not routinely used as part of the daily operation of the centre. This practice limited residents' opportunities to make meaningful choices regarding where they wished to dine and did not reflect a rights-based approach to care. Furthermore, it reduced opportunities for social engagement during mealtimes. This matter is discussed further under Regulation 9: Residents' Rights.

Residents were provided with a variety of opportunities to participate in social and recreational activities throughout the day. A dedicated staff member coordinated the daily activities programme, and staff were observed actively encouraging residents to participate. Residents were observed enjoying a music session hosted by the Office of Public Works in the main sitting room during the morning. In the afternoon, a musician who attends the centre weekly, facilitated a music session in the external courtyard at the rear of the premises. This was attended by over 20 residents. The atmosphere was lively and social, with music, conversation, and laughter evident throughout the session.Residents were served ice cream and drinks, and staff were observed singing and dancing with residents, further enhancing the positive and engaging environment. Residents told the inspector that they enjoyed the activities programme and described it as an important and enjoyable part of their daily lives.

A significant number of residents were living with dementia or cognitive impairment and were therefore unable to express their views on the quality of life within the centre. However, residents who were unable to verbally communicate their needs appeared relaxed, content, and comfortable in the company of staff. Interactions observed between staff and residents were warm and respectful, and residents appeared at ease in their surroundings.

Visitors were observed coming in and out of the centre throughout the day. The inspector spoke with four visitors who stated that they were happy and grateful for the care provided to their loved ones. Visitors said that they were kept updated with any changes or concerns, and that if they had any issues they felt confident to bring them to the attention of any member of staff. Visitors were also observed to join residents during the music sessions on the day, contributing to the social atmosphere.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how

these arrangements impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This was an unannounced inspection carried out by an inspector of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The findings of the inspection indicated that some improvements had been achieved since the previous inspection, particularly in relation to complaints management and the provision of social activities and stimulation for residents. However, the inspection also found that oversight arrangements relating to fire safety and the management of restrictive practices were not fully effective. In addition, the provider had not ensured that residents were consistently afforded a positive dining experience within the centre. This was a repeated finding from previous inspections and indicated that sufficient action had not been taken to address the issue. These findings, along with other areas requiring improvement, are discussed in further detail under the relevant regulations throughout this report.

The registered provider of is the Health Service Executive (HSE). There was a clearly defined management structure in place. The senior management team with responsibility for the centre included a General Manager for Older Persons, as well as a person in charge. The provider had notified the Chief inspector of the appointment of the general manager for older persons as a person participating in management (PPIM) since the previous inspection. The nurse management structure within the centre centre remained unchanged since the previous inspection. The person in charge had overall responsibility for the governance and management of service on a day-to-day basis, and was supported by a clinical nurse manager.

A review of staff rosters and observations made on the day of inspection indicated that there were sufficient numbers of nursing and care staff on duty, with the appropriate knowledge, skills and experience to meet the assessed needs of residents, taking account of the size and layout of the designated centre. A minimum of two nurses were on duty at all times.

There was an ongoing training programme in place to ensure that staff received relevant and up-to-date training to support them in carrying out their roles and responsibilities. Arrangements were also in place for the supervision and support of staff. The management team were present in the centre five days per week, with on-call management support available at weekends, providing oversight of day-to-day practices and operations within the centre.

Management systems were in place to monitor and review the quality of care and services provided to residents. Clinical and environmental audits were undertaken

regularly, including audits of care planning, infection prevention and control, and medicines management. Weekly key performance indicators (KPIs) were collected and monitored in areas such as falls and infections. However, the inspector found that the majority of audits reported 100% compliance, despite inspection findings identifying issues that had not been detected through the centre's internal audit processes. In addition, the systems for monitoring and overseeing restrictive practices and fire safety required strengthening to provide effective assurance regarding compliance and resident safety. These findings are addressed under Regulation 23 and within the Quality and Safety section of this report.

There were management systems in place to monitor and review the quality of the service provided for residents. Clinical and environmental audits were completed which included reviews of care planning, falls management, wound management, infection control and medicines management. Weekly key performance indicators (KPIs) were being collected on areas such as falls, infection, restraint and wounds.However, the inspector noted that the majority of audits achieved compliance of 100% and findings of this inspection were not captured through the centre's own audit process. The management systems in place to monitor restraint and fire safety in the centre also required strengthening. These findings are actioned under Regulation 23 and in the Quality and Safety section of this report.

All records requested during the inspection were made readily available to the inspector. Records were maintained in a neat, orderly manner and were stored securely. Documentation relating to staff personnel files, adverse incidents and complaints was maintained in line with the requirements of the regulations. The provider had policies and procedures in place as required under Schedule 5 of the regulations. These were available in paper format and were easily accessible to staff when required. However, a review of a sample of policies found that some had not been reviewed and updated within the required three-year time frame. As a result, the provider could not demonstrate full compliance with regulatory requirements relating to the review of written policies and procedures. This finding is discussed further under Regulation 4: Written Policies and Procedures.

Regulation 16: Training and staff development

Improvements were noted in staff training since the previous inspection. Staff had access to regular training and refresher training to ensure their mandatory training was up to date. All staff were up-to-date with their fire safety, moving and handling, and safeguarding training. Records showed that staff had access to infection prevention and control updates, and training included the standards for the prevention and control of health care-associated infections published by the Authority.

Judgment: Compliant

Regulation 21: Records

The inspector reviewed a sample of staff personnel files and found that they contained all required documentation in accordance with Schedule 2 of the regulations. This included evidence of vetting disclosures completed in line with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, two satisfactory references, and a documented employment history for each staff member. The inspector also verified that all nursing staff were registered with the Nursing and Midwifery Board of Ireland (NMBI) and that their registration status and Personal Identification Number (PIN) details were current and up to date.

Judgment: Compliant

Regulation 23: Governance and management

Although governance arrangements were established, they were not sufficiently effective across all areas to ensure the delivery of a safe, appropriate, consistent, and well-monitored service. This was evidenced by:

- A review of fire precautions within the centre found that the provider had not completed all actions identified in the compliance plan submitted following the previous inspection in September 2025. Specifically, the provider had committed to undertaking monthly compartment evacuation drills; however, these drills had not been completed as outlined in the compliance plan. As a result, the provider could not demonstrate that staff had regular opportunities to practice the safe and timely evacuation of residents from individual fire compartments.This is further detailed under Regulation 28.
- The systems in place to ensure that residents were afforded a dining experience in the centre were not effective, as detailed under Regulation 9.
- There was a lack of oversight of auditing to identify trends, evaluate the effectiveness of care delivery, enhance safety and promote quality improvement.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of incidents occurring in the centre was well maintained. All incidents had been reported in writing to the Chief Inspector, as required under the regulations, within the required time period.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had an accessible and effective complaints procedure in place, which included a clearly defined review process. The procedure outlined the required time lines for the investigation and review of complaints and was prominently displayed within the centre. It also provided details of the nominated complaints officer and review officer, in addition to information on how residents could access an independent advocacy service.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had written policies ad procedures in place as required under Schedule 5. However, some had not been reviewed and updated within three years as required by the regulation. Specifically:

- The admissions policy had expired in November 2025.
- The restraint policy had expired in May 2026.
- The creation of and access of, retention of, maintenance of and destruction of records had expired in November 2024.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents living in Youghal Community Hospital were satisfied with the quality of care provided and valued the positive relationships they had developed with staff, who were observed to be kind, caring, and supportive. Evidence demonstrated effective consultation with residents, and their needs were being met through timely access to healthcare services and meaningful opportunities for social engagement. However, improvements were required in relation to the use of restraint, fire precautions, residents' rights, and care planning. These findings are discussed in more detail under the relevant regulations throughout this report.

Residents' care plans and daily nursing notes were recorded on an paper system. A sample of assessments and care plans were reviewed and found that, each resident had a care plan in place and these were formulated within 48 hours of admission, as per regulatory requirements. An assessment of residents health and social care needs was completed on admission and ensured that residents' individual care and support needs were being identified and could be met. However, some actions were required in ensuring that residents end of life wishes were documented, which is detailed under regulation 5: Individual Assessment and Care Planning.

There was good access to allied healthcare professionals including physiotherapist and occupational therapist. In addition, the centre also has access to dietetic, speech and language, tissue viability, and chiropody services. Residents were supported by the community mental health services and palliative care services if required. In the sample of files reviewed, information regarding the assessment, involvement and recommendations of these services was reflected. The inspector was satisfied that weight changes were well managed.

There were some precautions in place against the risk of fire in the centre. Emergency lighting and the fire alarm system was serviced every three months. A sample of fire doors were assessed and were observed to function effectively. Fire exits were unobstructed and were controlled through the fire alarm system to ensure they opened in the event of a fire emergency. Staff were provided with annual training in fire safety Overall, however, the inspector found that the current arrangements for oversight of fire safety management and systems to identify fire safety risks within the centre needed to be more robust to ensure the safety of residents as discussed under Regulation 28: Fire precautions.

Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) received care and support from staff that was kind, and respectful. Staff demonstrated an understanding of residents' individual needs and responded appropriately to support their well being. However, the centre was not actively promoting a restraint-free environment, and arrangements for monitoring and reviewing the use of restrictive practices were not sufficiently robust. These findings are discussed further under Regulation 7.

Residents independence was promoted, for example residents were encouraged to go home for weekends, into the local town centre or on holidays with family. There was evidence that residents were consulted with and participated in the organisation of the centre via residents meetings and from feedback provided by residents on the day of this inspection. Opportunities were provided to residents to participate in social and recreational activities, and to engage with others. However, as referenced in the first section of this report residents were not afforded an appropriate dining experience, which was a repeat finding on previous inspections of the centre.

Regulation 17: Premises

Some actions were required to ensure compliance with the requirements of Schedule 6. For example:

- The inspector observed inappropriate storage of equipment in the communal dining room and in a communal bathroom. This may impede residents' use of these facilities.
- Some chairs within the centre were observed to be damaged, with torn upholstery.
- Privacy curtains in some multi-occupancy bedrooms did not fully enclose residents' bed spaces, which may have adversely impacted their privacy and dignity.
- There was not sufficient dining space in the centre to cater for all residents living in the centre. The dining room could cater for up to nine residents, however there could be up to 31 residents living in the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Adequate precautions were in not in place against the risk of fire in the centre, evidenced by the following findings:

- The centre has one fire compartment containing nine beds, situated upstairs. Since the previous inspection, no simulated fire drills had been conducted to assess the evacuation of this compartment. Following the inspection, the provider was requested to complete a fire drill simulating the full evacuation of the compartment during periods of minimum staffing. Evidence submitted demonstrated that the evacuation was completed within acceptable timeframes. However, the provider is required to ensure that full compartment evacuation drills are undertaken regularly and that all staff participate to demonstrate and maintain competency in carrying out a safe and effective compartment evacuation.
- A summary of residents Personal Emergency Evacuation Plans (PEEP) were in place for staff to access in the event of a fire emergency. However, some of these records were not kept up-to-date and referred to multiple evacuation methods for residents. This could cause confusion in the event of an emergency. The management staff were requested to update these records immediately before completion of the inspection.
- Daily, weekly and monthly fire safety checklists were in place, which included checks of fire-fighting equipment, fire alarm testing, emergency lighting, means of escape and fire exit doors. However, the inspector identified gaps in the completion of these records, with several days over the previous month not signed as completed. These omissions were particularly evident at weekends and did not provide assurance that all required fire safety checks were being consistently carried out and documented.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Some actions were required in care planning evidenced by the following findings:

- End-of-life care plans did not contain sufficient detail to guide care delivery or clearly reflect residents' individual wishes and preferences.
- One resident's behavioural support plan had not been updated to reflect recent changes in their mood and behaviour.
- Social care plans were not consistently completed or updated to accurately reflect residents' personal interests, preferences, likes, and dislikes.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that residents had access to appropriate medical and allied health and social care professional support to meet their needs. Residents had a choice of general practitioner who attended the centre as required or requested. Residents were also supported with referral pathways an access to allied health and social care professionals. Wound care practices in the centre were good and based on evidence based nursing practice.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Significant action was required in the management of restraint as evidenced by the following findings:

- The centre's restraint register was not being maintained or monitored in accordance with the centre's policy. As identified on the previous inspection, there continued to be a high use of bed rails within the centre, with over 55% of residents using bed rails on the day of inspection. Furthermore, there was insufficient evidence to demonstrate that alternatives to bed rails had been considered or trialled prior to their use, in line with the centre's policy.
- The inspector also observed that multiple restrictive practices were in use for some residents, including bed rails, crash mats and sensor mats. However, discussions with staff did not provide clear evidence of the rationale for

implementing these measures or demonstrate that they had been subject to regular review.

- Wander guards and sensor mats were not consistently identified or recorded as restrictive practices and were not being effectively monitored. For example, it was difficult to determine the number of residents who had been allocated these devices, indicating gaps in the recording and oversight of restrictive practices within the centre.
- A number of residents chose to smoke and were facilitated to do so in a designated external smoking area. However, a review of documentation and discussions with staff identified that residents were not permitted to smoke after 6.00 p.m. This restriction constituted a restrictive practice, as it limited residents' autonomy and freedom of choice. The inspector found that this restriction had not been implemented following consultation with residents. Furthermore, the restriction had not been identified or documented within the centre's restraint register, resulting in inadequate oversight and governance of the practice.

Judgment: Not compliant

Regulation 9: Residents' rights

In response to the September 2025 inspection, the provider indicated in their compliance plan that the dining facilities would be available to residents and their use promoted within the centre. However, the inspector found that this commitment had not been implemented at the time of this inspection and the dining room was not in use. Furthermore, two residents told the inspector that the dining room was closed. This was an institutionalised practice, and had been a repeated findings of inspections of May 2024, October 2024 and September 2025. This practice did not promote residents rights, choice and dignity.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Youghal Community Hospital OSV-0000577

Inspection ID: MON-0051237

Date of inspection: 30/07/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Fire evacuation drills are now being undertaken on a monthly basis, rotating through all compartments. All staff have regular opportunities to participate in the practice of safe and timely evacuation of residents and to review the operation of the fire policy. • The dining room is now open for meals and the residents are encouraged to use the dining room. The dining room is undergoing some refurbishment at present to make it a more desirable and comfortable place for the residents to eat. There are no longer any items stored in the dining room, these items have been allocated a specific storage area. • The monthly audits in Youghal Community Hospital, carried out by staff nurses, are being reviewed each month by the CNM2/DON for accuracy and follow up. All staff nurses are completing A Practical Guide to Clinical Audit on HseLand to develop their auditing skills.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • The named schedule 5 policies are in the process of being reviewed and up-dated. We are undertaking this in conjunction with our practice development manager to ensure we are adhering to best practice and for consistency across all units.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Items are no longer stored in the dining room or in any of the communal bathrooms. These items were allocated storage space elsewhere.
• The chairs which were identified as being damaged or torn on the day of the inspection, were previously identified by staff as so and were refurbished or repaired as required by 4th August 2026.
• New privacy screens have been ordered for areas where there was inadequate coverage, we are awaiting delivery and installation of same.
• With the refurbishment of the dining room there will be increased capacity to accommodate more residents at meal times in the dining room.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Full compartment evacuation drills are now carried out monthly. All staff are given the opportunity to participate in the safe and effective evacuation using minimum staffing levels.
• The resident's Personal Emergency Evacuation Plans (PEEP) are kept up to date, with only one evacuation method for each resident indicated on the form.
• The daily, weekly and monthly fire checks are being kept up to date with reminders for the weekend staff to carry out and document the checks.

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:
• All care plans have been reviewed by the CNM2/DON. Care plans which had insufficient detail in any of the individual plans including end-of-life care, behavioural support and social care are in the process of being reviewed by the allocated nurse in collaboration with the resident in order to accurately reflect the residents' wishes and preferences. This practice of accurately reflecting the resident's wishes and preferences will be ongoing during admission and will be subject to regular review.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• The restraint register has been updated to reflect the current policy; it will be completed daily by the DON/CNMII/Nurse in Charge.

• All relevant care plans are being updated to demonstrate that alternative measures have been trialed and what the outcome was prior to the implementation of bedrails.

• One resident declined a trial and requested bed rails.

• The use of one or more types of restraint by a resident will be detailed in the care plan outlining a clear rationale for same and will be reviewed regularly as per current policy. These restraints are now documented clearly on the restraint register.

• Wander Guards and Sensor Mats are now included in the restraint register, they are identified as a restrictive practice in the resident's care plan with a clear rationale for their use, they will be reviewed regularly as per the current policy.

• The facility to smoke in Youghal Community Hospital is subject to an individual risk assessment. Due to decreased staffing after 6pm and again after 8pm supervision is not adequate to facilitate smoking for some residents after these times due to identified risk. There is no restriction on smoking times if the resident's family or friends are willing to supervise the resident. The smoking risk assessment and smoking care plan are being discussed with each relevant resident and are being updated to reflect that consultation. Reduced access to smoking after 6pm or 8pm (unless family supervision is available) is now clearly identified on the risk register and under regular review.

• Following a review of the use of restraints in Youghal Community Hospital, half bed rails and bed levers are being trialed for many of the residents. Efforts are being made to reduce the use of restrictive practices.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• The dining room is open and in use on a daily basis for meals in Youghal Community Hospital. All residents are being encouraged to use the dining room for their meals. The refurbishment of the dining room is ongoing with the intention of making it a more appealing place to congregate and eat. The dining room refurbishment should be complete by the end of this year, but the dining room will remain open as often as possible around the ongoing works.

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 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	28/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	31/07/2026

	reviewing fire precautions.			
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/07/2026
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	30/10/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/10/2026
Regulation 7(3)	The registered provider shall	Not Compliant	Orange	16/10/2026

	ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	28/09/2026