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:	08 September 2025
Centre ID:	OSV-0000577
Fieldwork ID:	MON-0044079

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, 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:	31

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
Monday 8 September 2025	09:30hrs to 17:30hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted over one day. The inspector met with the majority of residents during the day of this inspection and spoke to nine residents in detail, about their experience of living in Youghal Community Hospital. Residents were overwhelmingly positive when they spoke about the kindness and compassion of staff. They told the inspector that they were always treated with respect and they enjoyed the company of staff, many who knew them from the local area. A couple of residents stated they would like more things to do during the day, as some days there "wasn't much happening" and there were activities if "staff weren't too busy." Some residents were living with dementia and were unable to detail their experience of the service, however, they were observed by the inspector to be content and relaxed in their environment and in the company of other residents and staff.

On arrival to the centre the inspector met with the person in charge and the clinical nurse manager and was escorted on a walk around of the centre. 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. The centre was full on the day of this inspection. Bedroom accommodation consists of nine single bedrooms, nine twin bedrooms and one four bedded room. Three of these bedrooms had full en-suite facilities and for the majority of bedrooms, there were communal shower and toilet located within close proximity. The inspector observed that residents' bedrooms and communal areas within the centre were generally clean with the exception of some residents' bedside lockers and window sills within bedrooms. These findings are further detailed under Regulation 17 and 27; Infection Control.

Staff were observed in the morning attending to residents requests for assistance with their care. Two residents were up and dressed in the downstairs sitting room and told the inspector that they could choose what time to get up from bed in the morning. On the second floor, the inspector observed three residents were eating their breakfast on chairs on the corridor outside of their bedrooms. Discussions with staff indicated that this was common day-to-day practice. This did not respect residents' rights and is actioned under Regulation 9.

The inspector noted that some resident bedrooms were personalised with items such as photographs, decorative quilts, ornaments and soft furnishings and it was evident that some rooms were being prepared for painting. Bedrooms were found to contain sufficient storage for residents to store their clothes. However, for some residents the layout of their room did not facilitate them having a locker beside their bed and lockers were situated at the end of the bed. There were other areas of the centre that were in a poor state of repair, such as bedroom flooring and one

wardrobe was seen to be broken. These and other findings in relation to the premises are detailed under Regulation 17. There was access to a television and call bells in all bedrooms.

Communal space in the centre was predominately on the ground floor and it consisted of a sitting room, visitor's room and a dining room. However, it was limited on the second floor of the centre. Specifically, it consisted of a sitting room and a quiet room. Each of these rooms could only accommodate a maximum of two residents at a time. Coupled with this, for residents in wheelchairs, access was difficult due to the size and shape of the rooms. As a result of this lack of space, the inspector observed that many residents residing on this floor spent their day on a chair beside their bed or were situated on the corridor beside a window. The inspector saw that only one resident independently used the lift and mobilised downstairs. The inspector found the practice of residents not having choice in where they spent their day was not in line with a rights based approach to care and these institutionalised practices and had been practices identified in the centre on previous inspections and appropriate action had not been taken and they are further outlined under Regulation 9.

It was evident to the inspector that friends and families were facilitated to visit residents and the inspector had the opportunity to meet with three visitors, over the course of day. Visitors who spoke with the inspector were very happy with the care and support their loved ones received. The inspector observed nice interactions between residents and staff during the day. It was evident that staff knew residents personal preferences and staff engaged positively and interacted respectfully with residents. Residents told the inspector that staff were always quick to provide assistance with anything they needed. Staff that spoke with the inspector were knowledgeable about residents and their individual needs. A large proportion of staff had worked in the centre for a number of years and it was evident that the staff knew the residents well and were familiar with the residents' daily routines and preferences for care and support.

Throughout the inspection, approximately nine residents were seen to spend their day in the sitting room downstairs. Some residents told the inspector that the day could be long and they would like more activities. One resident told the inspector that the days that there were activities in the centre were "great fun" such as on a Saturday when a musician played, or when there was a game of bingo. The inspector saw that while an activities schedule was in place and it detailed hair and make-up and bingo for Mondays, these were not provided on the day and there was no staff member assigned to activities or social care due to staff planned and unplanned leave. The inspector observed residents spending extended periods of time in the sitting room, and in their bedrooms with no social engagement. This meant that the only social engagement for residents was when they were receiving direct care from staff.

There is one dining rooms in the centre, which had been added a number of years ago. The inspector spent time observing the dining experience for residents at dinner time. For the six residents who attended the dining room they were observed to have a pleasant, sociable and relaxed experience, where they chatted to each

other and a member of staff was available to assist them if necessary. Residents had a choice of meals from a menu, which was updated daily. Residents told the inspector that they enjoyed mealtimes, the food was good and they always could get an alternative to the menu, if they did not like what was offered. However, the inspector saw that the majority of residents living in the centre were not afforded a dining experience and remained in the sitting room with a bed table beside them, or beside their bed for their meals.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection which took place over one day, to monitor ongoing compliance with the regulations. The findings of this inspection were that although there was a clearly defined management structure in place which was accountable for the delivery of the service some actions were required to comply with the regulations. Specifically in relation to residents' rights, governance and management, care planning, the premises and complaints management. These will be further detailed under the relevant regulations in this report.

The registered provider of Youghal Community Hospital 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 the Head of Older Person Services and a General Manager for Older Persons, as well as a person in charge. There had been a change in person in charge since the previous inspection and they were in post five months at the time of this inspection. They worked full time in the centre and were supported in their management role by a clinical nurse manager. There was also a team of nursing, health care, household, catering, and maintenance staff. The service is also supported by national centralised departments, such as human resources, fire and estates and practice development. There was clear lines of accountability and responsibility.

The provider had been granted a certificate of renewal of registration of the centre, effective from May 2024. As part of this process the Chief Inspector assesses the governance and management arrangements of the registered provider. Although it was evident that there was a defined management structure in place and the lines of authority and accountability were outlined in the centre's statement of purpose, the senior managers with responsibility for the centre were not named as persons participating in management on the centre's registration. The provider was required to review these arrangements and was afforded until October 31st, 2024 to do so. However, at the time of this inspection, these senior managers had yet to be named

and the restrictive condition remained on the centre's registration. This finding is actioned under Regulation 23; Governance and Management.

On the day of the inspection there were adequate numbers of nurses and healthcare staff employed to care for residents. There was an ongoing comprehensive schedule of training in place in areas such as fire safety, safeguarding vulnerable adults, infection control and people moving and handling. Staff training was being well monitored by the management team. Although the majority of mandatory training was in date, cardiopulmonary resuscitation (CPR) training for four nurses had expired, as actioned under Regulation 16. There was a quality management system in place which included an electronic audit system for 2025, to monitor the service delivery. Although some of these audits were seen to be carried out, improvement action plans were not consistently developed or subject to time frames, which meant that some deficits and issues could not be addressed. This finding is actioned under Regulation 23.

The inspector followed up on the findings of the previous inspection of October 2024 in relation to fire precautions. Although it was evident that the monitoring of evacuations sheets had been enhanced the inspector was not assured that evacuation drills were simulated to ensure staff were competent in the procedure if there was an emergency. This is further detailed under Regulation 23.

There were effective lines of communication within the service, as evidenced by the records of quality and governance meetings taking place between the person in charge of the centre and the provider's senior management team as well as internal meetings with all departments. Staff met on a daily basis to discuss residents clinical care requirements and it was evident that they knew residents well. Accidents and incidents were recorded, appropriate action was taken, and they were followed up on and reviewed. All notifications required to be submitted to the Chief Inspector were submitted by the person in charge within the required time frame.

Complaints were discussed with the person in charge on inspection and records were reviewed. It was evident that feedback was welcome from residents and relatives. Nonetheless, action was required to ensure the complainant was informed of the outcome of the complaint and the process was on display in the centre. These findings are further detailed under Regulation 34.

Regulation 14: Persons in charge

There was a full-time person in charge employed in the centre with the relevant qualifications and experience, as required by the regulations to undertake the role. They had been employed as person in charge since April 2025 and had a post registration management qualification. The person in charge was knowledgeable of individual residents' clinical needs.

Judgment: Compliant

Regulation 15: Staffing

The centre had sufficient resources to ensure effective delivery of care to residents. The centre had a stable team of staff which ensured that residents benefited from continuity of care from staff who knew their individual needs. The person in charge and the clinical nurse manager supervised care delivery and were supernumerary when on duty Monday to Friday. There was a minimum of two registered nurses on duty on every 12 hour shift.

Judgment: Compliant

Regulation 16: Training and staff development

Cardiopulmonary resuscitation (CPR) training for four registered nurses had expired. This was mandatory training as per the centres training policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

This inspection found that some of the management systems required action as evidenced by the following findings:

- The provider had not ensured that staffing resources were effectively organised and managed in the centre to ensure that residents were afforded the opportunity to participate in activities daily.
- The systems in place to ensure residents rights were upheld in the centre required were not sufficiently robust, as detailed under Regulation 9.
- The monitoring of the service required improvement as it was found that audits were not carried out as scheduled and there were not always associated action places to address findings. These were necessary to review and monitor practices within the centre and to implement improvements.
- Fire drill records available did not adequately identify or provide assurance that residents could be evacuated in a timely manner, from the largest compartments (nine residents upstairs) when staffing levels were at their lowest. This was a finding on the previous inspection, however, it had not been adequately addressed by the provider.

The management structure required to be reviewed. Specifically findings of this

inspection were that the registered provider had not complied with the restrictive condition placed on the centres registration. This condition stated that: "The registered provider shall, by 31 October 2024, submit to the Chief Inspector the information and documentation set out in Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 as amended in relation to any person who participates or will participate in the management of the designated centre".

Judgment: Not 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 complaints management system was not in line with the regulatory requirements, evidenced by the following findings:

- There was not always evidence that the registered provider had provided a response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, improvements recommended and details of the review process.
- The complaints procedure was not on display in the centre and the procedure identified a complaints officer and a review officer that no longer worked in the centre.

Judgment: Substantially compliant

Quality and safety

This inspection found that the interactions between residents and staff were kind and respectful in Youghal Community Hospital and residents were satisfied with the healthcare they received. Residents reported that the staff made them feel safe and content living in the centre. Nonetheless, the inspector found that action was required to comply with regulations in relation to residents' rights, care planning and

the premises. These will be further detailed under the relevant regulations of this report.

Pre-admission assessments were completed to ensure that the centre could adequately meet the needs of prospective residents. Residents were assessed using validated tools and care plans were initiated within 48 hours of admission to the centre, in line with regulatory requirements. The centre had a paper care record system and each resident had a care plan in place, updated four monthly. However, on review of a sample of care plan documents, some did not contain adequate information to direct care and were not updated when care needs of the resident changed. These findings are further detailed under Regulation 5.

Residents were provided with a good standard of evidence based health and nursing care and support. Residents had timely access to general practitioners from a local practices. Residents also had good access to other allied health professionals such as speech and language therapists, a dietitian and specialist medical services such as community palliative care and community mental health services as required.

There was evidence that residents who presented with responsive behaviours were responded to in a very dignified and person-centred way. Although there was a high incidence of bedrails in use in the centre on the day of this inspection there was evidence of appropriate risk assessments in place for all uses of restraint in the centre. These included multidisciplinary input, evidence of regular reviews in consultation with residents, and measures to control the risks of restraint use such as monitoring and scheduled release of the restraints as required. Nonetheless, further action was required to ensure that alternatives were trialled, as recommended by national policy.

There were adequate arrangements in place to monitor residents at risk of malnutrition or dehydration. This included weekly weights, maintaining a food intake monitoring chart and timely referral to dietetic and speech and language services, to ensure best outcomes for residents. Each resident had a nutritional assessment completed using a validated assessment tool. Modified diets and specialised diets, as prescribed by healthcare or dietetic staff were implemented and adhered to.

Residents had access to television, radio, newspapers and books. Religious services and resources were also available and had access to an independent advocacy service and details regarding this service were advertised in the centre. However, action was required pertaining to the frequency of residents meetings, the provision of activities and access to a dining experience. These findings are addressed under Regulation 9.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive and visitors spoke positively

about the care their loved ones received in the centre.

Judgment: Compliant

Regulation 17: Premises

As found on the previous inspection not all aspects of the premises conformed to the matters set out in Scheduled 6 of the regulations: For example:

- The layout of some rooms did not ensure that residents could have a locker beside their bed.
- One wardrobe was observed to be broken and the door was falling off its hinges.
- Flooring in some bedrooms was observed to be stained, dented and damaged.
- A sensor mat was observed to have frayed electrical wires.
- Some privacy screens did not close fully around the residents bed space.
- There was inappropriate storage of items on top of wardrobes in bedrooms.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents who required assistance were provided with it in an unhurried and respectful manner. Texture modified diets appeared appetising and wholesome. Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services (2018), however, further action is required to be fully compliant. For example:

- Nebuliser masks and machines were observed unclean in two residents' bedrooms and they were not stored in the recommended boxes, as per the centres policy.
- Some residents' bedside lockers and window sills in bedrooms were visibly

unclean and cluttered. Some contained open mouth care trays and products for skin care and wound care dressings. Therefore, the effectiveness of these products could not be assured as they were not stored appropriately.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of three residents' care records. Some action was required to ensure that they provided staff with adequate guidance and direction to provide safe and appropriate care as needed for residents. For example:

- Care plans were not always reviewed or updated when a resident's condition changed.
- A resident requiring regular monitoring of their blood sugar did not have the frequency of this documented in their care plan.
- Although assessment tools were being used to monitor the risk of falls, malnutrition, assessment of cognition and dependency levels, these were not always used to inform care planning.

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 and access to allied health and social care professionals. There was a low incidence of pressure ulcer development within the centre.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There was a high incidence of bed rail usage in the centre at over 50%. From discussion with staff and from review of documentation it was found that action was required to ensure that restraints are not used as a result of culture and family wishes and requests. This will ensure that restraints are only in place due a residents request or post a completed clinical assessment of need.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector found that residents' right and choices were not always promoted and respected in the centre, evidenced by the following findings:

- The activities programme was reviewed and was found to be very limited. The inspector observed that residents spent a considerable amount of time with minimal stimulating activity. There was not a staff member allocated to activities on some days of the week and if there was a deficit in staff in any other department activities were not available on that given day.
- Residents did not have a choice with regards to a dining experience. Although there were 31 residents living in the centre, six residents were observed being facilitated to dine in the dining room. The remainder of the residents were observed sitting in the downstairs sitting room with a bed table in front of them, in the hallways upstairs consuming meals or on a chair beside their bed. These institutionalised practices, which had also been findings of inspections of May 2024 and October 2024 had not been addressed by the provider and did not promote residents rights and dignity.
- Residents' meetings were not convened regularly, to ensure residents had an opportunity to express their concerns or wishes. There had been one residents meeting in the previous 12 month period. This was contrary to the centres statement of purpose which stated that residents would be consulted with about the running of the centre four times per year.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Youghal Community Hospital OSV-0000577

Inspection ID: MON-0044079

Date of inspection: 08/09/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Training is organised for mid-November for the four staff members whose CPR training was out of date. Staff have been reminded to monitor their mandatory training and have an awareness of any upcoming expiring training certificates. The training Matrix will be reviewed on a regular basis by the CNM and any upcoming expiring certificates will be notified to the staff member. Training will be included as an agenda item of staff meetings going forward.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • At present activities are provided by an external service, five days of the week, on the remaining two days, going forward staff who are assigned to provide activities will no longer replace staff leave. A full review of the roster has taken place to ensure an even spread of activities throughout the week. There is ongoing meaningful engagement by all staff with all of the residents in relation to the activities programme and this will be discussed with residents at the next resident meeting. • Residents are given the choice daily, as to where they would like to dine, their options are the dining room, the dayroom, and/or at their bedside. The dining room is always	

promoted as the best option for residents. Resident's wishes are recorded in their care plan and can be changed according to their daily preference. Meals are no longer provided on the corridor. Despite encouragement residents continue to express a wish to dine in the day room or at their bedside, this wish is respected.

• An audit monitoring system has been put in place and will be reviewed weekly by the CNM to ensure a closer monitoring of the audit schedule and in particular a focus will be placed on monitoring any action plans that have been put in place.

• Fire drills of compartments (not zones) are carried out monthly using night time staffing levels (4 staff) and response is documented. Fire drills and evacuations are randomly rotated, as are the compartments being evacuated.
Each zone on the fire panel represents a number of compartments.
Within the zone referred to, zone 6 there are 3 separate compartments with 2, 3 and 4 residents in each compartment, each room within those compartments is fitted with a half hour fire door. The largest compartment in Youghal Community Hospital contains 4 residents.
We will have an evacuation drill of one of the compartments in this zone on the 26th of this month.

• The statement of purpose has been updated to ensure the current management structure is referenced in all sections.

• The person who will participate in management of the Designated center is the Person in Charge, and their Qualifications have already been submitted to the Chief Inspector pursuant to section(i) b (ii).The person in charge is supported by the older Persons Services Cork Kerry Community Healthcare.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All complaints will be logged and processed according to the complaints procedure ensuring the complainant has been informed in writing about whether the complaint has been upheld or not, the reasons for that decision, improvements recommended and details of the review process. This will be recorded on the complaints template in use and reviewed regularly by the PIC to ensure the process is being followed accordingly.

• An up to date complaints procedure is now on display in YCH with the current complaints officer and review officer identified on it.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The rooms identified have been reorganised to ensure that all residents now have an accessible locker beside their bed.

• The broken wardrobe has been replaced.

• Flooring will be replaced in the bedrooms where the flooring is damaged, aiming for an expected date of completion of the works of end of January 2026.

• The damaged sensor mat has been removed from service. All sensor mats will be assessed weekly for damage.

• A review of the privacy screens in place will be carried out and alternative privacy screens will be sourced if necessary.

• Items are no longer stored on top of wardrobes all staff have been made aware of this and will be reminded at the daily safety pause. Random checks will be carried out and discussed at ward meetings.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The Aerogen nebulization system is now being used in YCH. The resident's individual aerosolization unit is kept in a closed box, with the resident's name on it, on the drug trolley.

• All wound care products are kept in the clinical room, any open packages are discarded after each dressing change.

• Each resident has an oral care box with a lid for storage of their oral care products including mouth care trays.

Only resident's personal items are displayed on the window ledges and lockers as determined by the resident.

Each resident has an assigned carer who ensures their bedspace is kept neat and tidy and in line with the residents wishes, all carers will be reminded to ensure that all areas

are kept clean at all times.

Random checks will be carried out, outcomes will be discussed at ward meetings and staff will be reminded of all actions to be taken at the daily safety pause meeting.

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 will be audited using the Viclarity assessment tools for documentation on a scheduled basis and action plans created and followed through. Staff will be reminded at our daily safety pause meeting to ensure that all changes are documented.

• A resident with particularly complex needs who also had type one diabetes required frequent monitoring of their blood sugar. As their needs were so multifaceted a regular schedule of blood sugar readings could not be established as each reading determined when the next reading would be taken. There was extremely close observation of this resident and their blood sugars. The frequency of these tests will be recorded in their Care Plan going forward.

• Staff will be reminded to ensure that assessment tools will be used to inform care planning.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

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

• All bed rail usage is audited using the Viclarity assessment tool. Bed rails are only used if the resident themselves requests them, or if there is an identified need following a clinical/risk assessment.

Assessments are carried out 4 monthly or sooner if requested/required and documented in the resident's care plan.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• At present activities are provided by an external services five days of the week, on the remaining two days, going forward staff who are assigned to provide activities will not be used to replace staff leaves.
Staff will receive further training in providing meaningful activities for the residents. A review of the roster has taken place to ensure an even spread of activities throughout the week.
There is ongoing meaningful engagement by all staff with the residents and an upcoming residents meeting will allow these issues to be addressed.

• Residents are always given a choice as to where they would like to dine, their options are the dining room, the dayroom, and/or at their bedside. The dining room is always promoted as the best option for residents. Resident's wishes are recorded in their care plan and can be changed according to their wishes. Meals are no longer provided on the corridor. Despite encouragement residents continue to express a wish to dine in the day room or at their bedside, this wish is respected.

• There will be closer monitoring of the audit schedule, particularly following through all action plans.

• Residents' meetings are facilitated quarterly by Elderwell. Management meets informally with each resident 2-3 times a week and listens and responds to any concerns they might have. Elderwell will provide meeting notes to the PIC following these meetings and staff will engage with Elderwell in advance of the proposed meetings to ensure issues raised are addressed.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/11/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/01/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	20/10/2025
Regulation	The registered	Not Compliant	Orange	20/10/2025

23(1)(d)	provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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	31/10/2025
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	20/10/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response	Substantially Compliant	Yellow	20/10/2025

	informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.			
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	20/10/2025
Regulation 7(3)	The registered provider shall 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.	Substantially Compliant	Yellow	20/10/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	20/10/2025
Regulation 9(3)(a)	A registered provider shall, in	Not Compliant	Orange	20/10/2025

	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.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	20/10/2025