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:	Castletownbere Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Castletownbere, Cork
Type of inspection:	Unannounced
Date of inspection:	18 August 2025
Centre ID:	OSV-0000601
Fieldwork ID:	MON-0044078

About the designated centre

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

Castletownbere Community Hospital was established as a residential centre in 1932. The building is single-storey and it was originally a former coastguard station. It is managed by the Health Service Executive (HSE) and provides long stay, respite, community support and palliative care for the local community. The centre is registered to accommodate 31 residents, male and female aged 18 to 65. Residents are accommodated in two four-bedded rooms, four three-bedded rooms, three twin rooms, and five single rooms. En-suite toilets and showers are available in all rooms with the exception of one single room. Communal space within the centre consists of two sitting rooms, a dining room, a visitors room and a family room. The external grounds are well maintained with ample car parking facilities. Nursing care is provided on a 24-hour basis supported by a team of health care assistants and allied health professionals including a medical officer.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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 18 August 2025	16:30hrs to 20:40hrs	Breeda Desmond	Lead
Tuesday 19 August 2025	08:20hrs to 15:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

Residents spoken with on the day of inspection were happy with the care they received and complimentary of the service provided. The inspector met with many of the residents living in the centre and spoke with ten residents in more detail to gain insight into their lived experience there. Residents spoke very highly of all the staff, the activities and the food served. The inspector spoke with three visitors who reported that staff were outstanding. One said that the kindness and thoughtfulness of staff was exceptional saying 'it's a lot of little things that make the place so special'.

Castletownbere Community Hospital is a residential designated centre which provides care for both male and female adults, with a range of dependencies and needs, and can accommodate 31 residents. It is a single storey building situated on a HSE campus which also accommodates the ambulance bay and primary health care facilities. The main entrance is wheelchair accessible and leads into a reception area where information such as the health and safety statement, nursing home registration, advocacy services and the complaints procedure are displayed.

There were 23 residents living in the centre at the time of this inspection; one resident was admitted during the inspection and another discharged. The inspector arrived in Castletownbere Community Hospital at 4:30pm on the first evening of the inspection. The inspector spoke with several residents in their bedrooms who explained that there was a cello recital on in the day room from 2pm – 3:30pm following which they were brought back to their bedrooms. They said that the music was beautiful and that they really enjoyed it. The evening meal was due to be served at 5pm, however, tables were not set for the meal as meals were to be served in bedrooms. The inspector queried this and residents were invited to the day room for their meal. Seven residents came to the day room as they prefer this room to the dining room. Residents sat together at one long table and chatted. Two residents were served initially and the remainder waited until residents in bedrooms were served, and then they were served. Staff stayed with residents and chatted after the meal and the atmosphere was relaxed and lovely social interaction was observed. Residents said that the food was gorgeous and that they really enjoyed their meal.

The activities programme displayed showed a variety of activities such as arts for health, live music twice a week, pet therapy on Mondays, and bingo for example; mass was facilitated in the centre on a weekly basis. On the first day of inspection, a cello recital was scheduled on the activities programme from 2pm – 5pm, however, as mentioned heretofore, this finished at 3:30pm and residents were returned to their bedrooms. On the second day of inspection, residents were accompanied to the day room in the morning following personal care. The activities staff was very familiar with residents and their choices and an Elvis concert was initially shown on the TV where a sing-song started immediately with residents. The activities staff member had a beautiful voice and all through the morning a beautiful sing-song was

heard. Other residents sat and enjoyed the entertainment while at the same time, read the news paper. When Elvis was finished another 60's concert was shown and residents were familiar with this repertoire as well and sang along. Residents were seen to really enjoy the morning. In the afternoon, a regular musician and singer provided entertainment for residents. She was familiar with their 'party pieces' and encouraged residents to take part, and they were seen to have great fun and entertainment.

The inspector attended the staff handover from night duty to day duty and there was excellent information-sharing regarding all aspects of resident care. The inspector noted that residents had their breakfast either in bed or in their bedrooms. Following which, staff provided personal care to residents.

The majority of residents living in the centre resided in shared bedrooms. There were two four bedded rooms, four triple rooms, three twin rooms, and five single bedrooms. All but one bedroom had en-suite facilities; this bedroom had shower and toilet facilities in close proximity directly opposite the bedroom. All residents had access to double wardrobes as part of their personal storage space. Some residents' bed spaces were personalised with pictures from home and soft furnishings. Some televisions in multi-occupancy bedrooms continued to be mounted very high and inaccessible for residents to view either in bed or from a bedside chair. The person in charge explained that this was to be addressed shortly.

The chapel was a beautiful peaceful space with stained glass windows and seating for residents. Chairs were stacked on the corridor opposite the chapel on the first day of inspection and these were removed by the second day. The centre was clean and appeared well maintained.

Communal space available to residents included a large day room overlooking the harbour, a dining room, a sitting room near the chapel, and a smaller sitting room/family room. Relatives spoken with said they used the family room a lot, especially when a few family members visited together; it enabled them to chat and play cards when visiting. Directional signage to orientate residents and prevent disorientation and confusion was installed following the findings of the last inspection.

Since the last inspection, the hairdressing room was refurbished. It had two hairdresser's sinks, a beautiful two-seater couch and an arm chair. The person in charge explained that they were in the process of decorating the room with murals, and had commissioned the Arts for Health staff to undertake this. They were in the process of liaising with residents to discuss and decide what murals and scenes they would like. They were also getting a large mirror and possibly shelving to accommodate a nail-bar to facilitated hand massage and nail painting here, as this is currently being done in residents' bedrooms, and this is welcomed.

Corridors were decorated with lovely artwork. A large colourful mural of a West Cork map adorned a full wall near the dining room, and depicted residents' home places in the surrounding areas. There were two wardrobes, a hoist, specialist wheelchair, and chair weighing scales on the corridor here even though it was an emergency

escape route.

Residents had access to the enclosed outdoor veranda areas; these doors were not locked which enabled residents to access these spaces independently. Residents that smoked, did so on the veranda; there was no smoking shelter or fire safety equipment here.

Residents were observed enjoying their main meal in the day room in accordance with their choice. There was sufficient staff available to assist residents who required assistance. Residents dining in their bedrooms were seen to be provided with appropriate assistance and staff actively engaged with residents while assisting them. Mid morning and mid-afternoon refreshments were provided including a choice of beverages, fruit, yogurt and biscuits.

Families and friends were seen visiting throughout the inspection. As the front door was locked, they were observed to wait until staff were available to gain entry or leave the centre.

Appropriate signage was displayed on doors indicating rooms storing oxygen or where oxygen was in use. Rooms such as the sluice room and rooms or trolleys with residents' notes were seen to be routinely open and accessible.

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 impact the quality and safety of the service being delivered.

Capacity and capability

This two-day un-announced inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations, and to follow up on the actions taken by the provider to address issues identified during the previous inspection in November 2024. The findings of this inspection were that all residents now had double wardrobes to store their clothing, and hairdressers room was refurbished. There was some improvement with staff training, Schedule 5 policies and residents' rights. The findings of this inspection evidenced that further actions were required regarding residents' rights and choice, complaints procedure displayed, residents' care records, fire safety precautions, and notifications to be returned to the regulator. These are further detailed under the relevant regulations.

The registered provider of this centre is the Health Service Executive (HSE). There are clear lines of accountability and the management team operating the day-to-day running of the centre comprise the person in charge and clinical nurse manager (CNM), supported by a team of nurses including senior enhanced nurses, multi-task attendants (duties include care provision and household cleaning roles), activities, catering, and administrative staff. Maintenance is provided from the HSE campus in

Bantry. At a more senior level, governance is provided by a general manager for older persons services who represents the registered provider. The centre also has support from centralised departments, such as finance, human resources, fire and estates, and practice development.

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.

The centre is registered to accommodate 31 residents, however, the inspector was informed that the centre could accommodate just 24 residents due to a shortfall in staff complement. This was a recurring finding over several inspections in Castletownbere Community Hospital.

The inspector found that there were good systems of communication via daily shift handovers, safety pauses, regular staff meetings and monthly quality and patient safety meetings. Records viewed by the inspector demonstrated that a weekly analysis of key clinical performance indicators was completed. While there was an audit schedule in place to support the management team to measure the quality of care provided to residents, several of the inspection findings were not identified as part of their audit process such as issues relating to residents' care records and medication management for example.

The levels and skill mix of staff working on the day of the inspection were sufficient to meet the needs of residents living in the centre. The proposed staff duty roster evidenced that while there was a roster line for staff allocated to meaningful activities, this line in the duty roster was routinely blank with no one assigned due to staffing deficits. The person in charge explained that care provision of residents and cleaning is prioritised when there are staff shortages.

A review of the incident and accident records and the post falls review log showed these were comprehensively maintained and that there were no incidents/accidents that required notification to the regulator. Nonetheless, other issues requiring notification were not submitted in accordance with regulatory requirements and these are detailed under Regulation 30: Notifications of incidents. While there was an accessible complaints procedure displayed, the older version of the complaints' procedure also remained displayed which outlined the persons in charge of the other community hospital that residents could access if required as part of the complaints procedure, however, recourse to this management structure was not part of their complaints procedure or policy. Schedule 5 policies and procedures required review to ensure they complied with specified regulatory requirements.

While improvement was noted in staff training with mandatory training up to date for all staff relating to fire safety, managing behaviours that challenge and

safeguarding, with further training scheduled to ensure training remained current, two staff employed in the centre for over a year did not have their manual handling training completed.

Regulation 14: Persons in charge

The person in charge was a nurse that worked full time and had the necessary experience and qualifications as specified in the regulations. She actively engaged with the regulator and documentation requested was provided promptly.

Judgment: Compliant

Regulation 15: Staffing

Action was required to ensure the duty roster was fulfilled to meet the holistic needs of residents:

- while the duty roster identified staff allocated to activities, this post was routinely vacant due to a short-fall in multi-task attendants, as their primary role was that of caring and household duties.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Action was required to ensure compliance with Regulation 16, as:

- two nurses, employed in the centre for over a year, did not have their manual handling and lifting training competed
- staff routinely returned residents to their bedrooms after activities rather than enable them to socialise in the day room, so better supervision of staff was required including meal-time supervision, to enable a social model of care to be promoted.

Judgment: Substantially compliant

Regulation 21: Records

Action was required to ensure records were maintained in accordance with specified regulatory requirements of Schedule :

- there were gaps in medication administration records so it could not be assured that residents received their prescribed medications.

Judgment: Substantially compliant

Regulation 23: Governance and management

Senior managers with responsibility for the service (as detailed in the statement of purpose) were not named as persons participating in management. Consequently, the Chief Inspector applied an additional condition to the registration of this centre, requiring:

"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."

The reason this additional condition was applied was in order for the Chief Inspector to be assured that the person in charge is adequately supported by a suitable management team and to be assured that there is a sufficient and clearly defined management structure in the designated centre. However, to date, the registered provider has not complied with this.

Some areas were identified with the governance and management of the service that required to be addressed. In particular:

- oversight of restraint use and residents' rights which are further detailed under Regulation 7: Managing behaviour that is challenging, and Regulation 9: Residents' rights
- oversight of notifications as there were deficits in the information included in quarterly notifications such as the restrictive practices in the centre of chemical medication, use of sensor mats, and secure doors, (this was a repeat finding) and some notifications as specified in the regulations were not submitted to the regulator (detailed under Regulation 31: Notifications of incidents).

Judgment: Not compliant

Regulation 31: Notification of incidents

Action was required to ensure notifications, as specified, were submitted to the regulator as follows:

- three episodes where the fire alarm was activated outside of routine checking were not notified to the regulator (these were submitted after the inspection)
- a review of one resident's medication chart showed that they received 'as required' PRNs, however, these were not included in the quarterly returns as specified as part of regulatory requirements
- alarm chair mats were in place, however, these were not included in the quarterly notifications as a restrictive practice, this was a repeat finding
- six monthly notifications (NF40) were not submitted (a NF40 was submitted following the inspection).

Judgment: Not compliant

Regulation 4: Written policies and procedures

Action was required to ensure policies and procedures in accordance with Schedule 5 were available and implemented into practice; this was a repeat finding:

- there were two different fire policies available to staff, the fire safety policy within the fire folder was out of date,
- the wound management policy had not been implemented in practice to enable best outcomes for the resident (as detailed under Regulation 6: Health care)
- the admissions policy was out of date
- the risk management policy was not updated to reflect the change in legislation in April 2025
- the complaint policy devolved most of the responsibility for complaints oversight to the person in charge, however, this responsibility was that of the registered provider
- while an accessible complaints procedure was displayed, the older version continued to be displayed; this had the names of the persons' in charge of the other community hospitals that residents could access as part of the complaints procedure, even though this information was obsolete and residents did not have recourse to this management structure,
- information relating to advocacy services required updating to reflect current information.

Judgment: Not compliant

Quality and safety

Residents spoke positively about the care and support they received, and that staff were friendly and kind. Visitors had similar feedback and were very complimentary about Castletownbere Community Hospital.

Residents had good access to GP service and an on-call GP service was provided for out-of-hours medical care. Residents had a multi-disciplinary team review every three months with the clinical nurse manager, GP and pharmacist to enable a robust medical review of each resident. Where residents were identified as requiring additional health and social care professional expertise, there was a system of referral in place and a review of the residents' care records showed that recommendations made by health and social care professionals were updated into the resident's plan of care. This included occupational therapy (OT) and dietician for example. As identified on the previous two inspections, improvement was required regarding wound care management to ensure a high standard of evidence based nursing care; this is further discussed under Regulation 6: Health care.

A sample of care documentation was reviewed. In the sample viewed, residents signed consent for interventions and care assessments, in accordance with a rights-based approach to care delivery. While validated assessment tools were in place to risk assess residents to ensure appropriate supports for their care needs, these were not consistently updated to reflect the needs and changing needs of residents. Associated care plans showed mixed findings, and while some had individualised detail to inform personal care, others did not. In addition, end of life care plans were not generally completed. This is further detailed under Regulation 5: Individual assessment and care plan.

Residents had access to pharmacy services and the pharmacist was facilitated to fulfil their obligations under the relevant legislation and guidance issued by the Pharmaceutical Society of Ireland. Additional records were available as part of the medication administration such as an antibiotic log with information relating to the antibiotic, dosage, duration and the rationale for the prescription; another document to support effective medication management included the pain assessment, analgesic and blood glucose monitoring. Nonetheless, issues were identified regarding medication management and these are detailed under Regulation 29: Medicines and pharmaceutical services.

Residents needs in relation to behavioural and psychological symptoms and signs of dementia were assessed, continuously reviewed and documented in the resident’s care plan with supports put in place to address identified needs. While restrictive practices were being monitored, some practices were not acknowledged as restrictive and so not included in the register in accordance with national policy. This is further detailed under Regulation 7.

Residents had access to an independent advocacy service and information regarding advocacy was displayed. There were opportunities for residents to meet with the management team and provide feedback on the quality of the service. Resident meetings were held three monthly and issues raised by residents was generally followed up in subsequent meetings.

While improvements were noted with regards to facilities for residents' occupation and recreation, other issues were identified regarding residents rights to choice throughout the day. This is further discussed under Regulation 9: Residents' rights.

A review of fire safety precautions showed that quarterly and annual fire safety certificates were up to date. Nonetheless, issues were identified regarding fire safety and these are detailed under Regulation 28: Fire precaution.

Regulation 10: Communication difficulties

Observation demonstrated that residents with additional communication needs were supported with specialist equipment for example. Staff were aware of residents' needs and were familiar with the specialist equipment to enable positive interaction with residents with whom they were seen to actively engage.

Judgment: Compliant

Regulation 11: Visits

Visitors were seen coming and going in the centre throughout the day. Staff welcomed them, actively engaged with visitors and provided updates on their relative. Feedback from visitors was very positive and families were very grateful to have a residential care setting nearby. Visitors spoken with said they used the family room regularly and that it was a great facility especially if a few people were visiting, they could go there and not disturb anyone.

Judgment: Compliant

Regulation 12: Personal possessions

Improvement was noted regarding residents' access to storage facilities, as now all residents had a double wardrobe to store their clothing.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents gave very positive feedback regarding the quality of food they received

and the menu choices for their meals.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The inspector found that the correspondence sent with a resident when they were temporarily transferred to another health care facility contained relevant information about the resident to ensure a comprehensive handover to enable the resident to be cared for in accordance with their current assessed needs. Upon transfer back to the centre, staff ensured that discharge information including updated prescriptions were available to enable best outcomes for the resident.

Judgment: Compliant

Regulation 28: Fire precautions

The following required attention to ensure fire safety as follows:

- while daily fire safety checks were being completed, furniture that partially obstructed emergency escape routes was not identified as an issue during the safety checks
- weekly checks of fire safety appliances were not routinely completed as part of their fire safety precautions
- some bedroom doors and other doors were seen to be kept open with small waste bins. This would prevent the fire doors to function should the fire alarm be activated,
- there was no smoking shelter available; residents that smoked had a chair on the veranda with a bucket of sand to extinguish their cigarettes; the fire extinguisher was located inside in the day room.
- residents did not have access to a safe smoking area. The smoking facilities comprised a designated area outside the day room with garden seating. The area was not sheltered, there was no fire safety equipment or call bell available to enable someone to call for help should they require assistance.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure residents' care documentation was maintained in

accordance with regulatory requirements, as follows:

- some assessments did not correlate with their associated care plan or interventions initiated to support residents' care needs, for example, a care plan stated that the resident had a red pressure area and their skin was impaired, and implemented appropriate pressure relieving mattress and cushion, however, their assessment stated they were not at risk of skin tears or pressure ulcers
- many of the care documents reviewed were not signed or dated by the staff completing the records in line with their policy
- while their was a chart to record details when a resident's catheter was changed to enable ease of access to catheter management history, this document was blank and had not been completed
- end of life care assessments and care plans were not routinely completed. While their care plan stated residents would be supported and their wishes respected and fulfilled, this would not be possible as their wishes had not been elucidated. Residents spoken with on inspection were well able to articulate their thoughts and views, so it would be an opportune time to seek out their wishes and preferences regarding their care should they become unwell.

Judgment: Substantially compliant

Regulation 6: Health care

The following required to be addressed to come into compliance with this regulation regarding wound care management:

- some wound care records did not detail the status of the wound; the associated assessments to determine whether the wound was healing and whether the treatment was effective were not routinely completed,
- another care plan stated that a wound was healed, however, the wound assessment and dressing record remained in the resident's open file
- recommendations regarding renewal of dressings were not followed; for example, one dressing completed on 23/06/25 was for redressing on 25th but this was not completed until 27th June. There were several examples of this in records examined.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Action was required to ensure that restraint was used only in accordance with the

Department of Health national policy:

- while there was a reduction in bedrail usage noted on the day of inspection it was not always evident from restrictive practice assessment documentation that alternatives had been trialled to enable the least restrictive option to be used,
- the main door and side doors were secure and residents did not have the access code to independently go outside if they had capacity.

Judgment: Not compliant

Regulation 9: Residents' rights

While some improvement was noted regarding residents' rights, further action was necessary to ensure the rights and choice of residents were protected:

- the inspector observed that residents had their breakfast either in bed or in their bedrooms and residents were not offered choice to attend the dining room for breakfast
- the inspector observed at 4:30pm, there were no residents in the day room or dining room. The staff had returned all residents to their bedrooms following the music session at 3:30pm. It was explained to the inspector that it was the routine that staff returned all residents to their bedroom. This practice did not facilitate residents to socialise in the day room with their friends in accordance with normal social engagement and then retire to their bedrooms at a later more normal time,
- TVs were mounted very high on the wall in some multi-occupancy bedrooms, this made it difficult for residents to view the TV from a bed or a bedside chair. The person in charge advised that this was due to be addressed shortly after the inspection as there was a delay due to a change in the electrical contractor to the service,
- privacy screens remained difficult to use as they were heavy and cumbersome, and had multiple-brakes to be released so most residents, in particular residents with mobility aids or those using wheelchairs, would be unable to use these independently; such equipment does not have regard to the needs of residents in accordance with their statement of purpose.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Castletownbere Community Hospital OSV-0000601

Inspection ID: MON-0044078

Date of inspection: 19/08/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A local recruitment campaign has been approved for multitask assistants, this will address the role to activities co-ordinator within the centre. [Date of Completion 30/11/2025]	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in charge has organised for the two nurses without manual handling and lifting training to attend scheduled training by the 24th September 2025 The Person in Charge has discussed with all team members the importance of promoting the social model of care within the centre. The Safety Pause is utilised daily by nursing management to support same. All staff are encouraging residents to remain in the day room for the evening meal (in accordance with their individual preferences and wishes on a daily basis) to encourage residents to continue to socialise. [Achieved 20/08/2025]	
Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Person in Charge has discussed the issue identified with all nursing staff. The Person in Charge will monitor medication charts to ensure there are no gaps in medication administration. The nursing team will undertake additional medication management audits to ensure practice is embedded. [Achieved 20/08/2025]

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider has made representations under section 50 Health Act 2007 [as amended] in relation to Regulation 23 Governance and Management that the person who will participate in management of the designated centre 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 South

The Management Team will ensure restrictive practice assessment documentation include alternatives had been trialled to enable the least restrictive option to be used. [Achieved 10/09/2025]

The Person in Charge has ensured all notification detailed under regulation 31 have been notified to HIQA. A new process is in place to ensure this continues to be delivered on time in time every time. [Achieved 20/08/2025]

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 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge will ensure all notifications are submitted to the regulator as follows:
• Fire alarm when activated outside of routine checking.
• PRN psychotropic drugs reviewed and added to quarterly returns.
• Alarm chair mats in place, included in the quarterly notifications as a restrictive practice.
• Six monthly notifications (NF40) summited.

(Achieved 20/08/2025)

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Person in Charge can confirm policies and procedures in accordance with Schedule 5 were available and implemented into practice;
Updated Fire policy is now available to staff. [Achieved 1/09/2025]
The Wound Management Policy is available and the Person in Charge has directed staff to adhere to the policy. In addition, the Person in Charge has arranged training to support identified staff. Skin Integrity clinical audits are being undertaken weekly to monitor and support best practice. [Achieved 09/09/2025]
The Admissions and Discharge Policy is under review and will be updated , circulated and in use by 30 12 2025

A process to review and update the Risk Management Policy and the Health and Safety policy has been established to ensure the Schedule 5 policies are reviewed and updated in accordance with regulatory requirements

The Management team have placed the updated complaints contact version on the display boards [Achieved 20/08/2025]
The Management Team have updated advocacy services information has been updated and to reflect current information. [Achieved 20/08/2025]

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Person in Charge has alerted all team members to the importance of keeping emergency escape routes free from obstruction. Weekly checks of fire safety appliances are now implemented and will be monitored by the Person in Charge. [Achieved 10/09/2025]

The Person in Charge has alerted all team members to the importance of adhering to the function of fire doors. The Person in Charge will monitor practice to ensure no bedroom doors are kept open with waste bins or any other object. Estates have been notified to replace doors that cannot be left open without obstructing the fire door. [To be achieved 30/09/2025].

The Person in Charge will ensure a smoking shelter will be constructed. This will include bucket of sand to extinguish cigarettes and a fire extinguisher. Also, a call bell must be in place to allow residents to call for help should they require assistance.
[To be achieved by 30/09/2025

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:
The Person in Charge will ensure that resident's assessments correlate with their associated care plan and all interventions initiated to support the residents' care needs, including the skin integrity care plan and assessment. The Person in Charge will monitor the results of weekly skin integrity clinical audits which will be undertaken until this practice in embedded at ward level. [Achieved 16/09/2025]

The Person in Charge can confirm that all care documents are signed and dated in line with their policy and will monitor practice going forward through clinical audit [Achieved 09/09/2025]

Training will be given on catheter management documentation. [To be achieved by 30/09/2025]

The Person in Charge can confirm that all end of life care plans are now completed and will monitor practice going forward through clinical audit. [11/09/2025]

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Person in Charge has devised an audit schedule to monitor practice to ensure wound care records detail the status of the wound; including assessments to determine whether the wound was healing and whether the treatment was effective or completed. In addition, appropriate timely renewal of dressings in accordance with recommendations will be monitored. [Achieved 20/08/2025]
The identified residents file has since been updated.

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 Person in Charge can confirm all restrictive practice assessment documentation clearly identifies alternative that have been trailed to ensure that the least restrictive option is practiced. [Achieved 14/09/2025]
The Person in Charge can confirm that the access code is avialble to residents at the main entrance and at the side doors facilitating resdient to go outsdie if they wish.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Person in Charge has remind staff to offer residents the choice to attend the dinning room for breakfast and will complete the paperwork stating the resdients choice [Achieved 11/09/2025]

The Person in Charge has discussed with all team members the importance of promoting the social model of care within the centre. The Safety Pause is utilised daily by nursing management to support same. All staff are encouraging residents to remain in the day room for the evening meal (in accordance with their individual preferences and wishes on a daily basis) to encourage residents to continue to socialise [Achieved 20/08/2025)

The Person in Charge is compleing a scope of works in relation to costing television arms that will enable movement of televisions closer to residents in line with personal requirements and preferences. [To be achieved 30/09/2025]

The Management Team will assess alternative privacy screens which are easy for resdients to move even if in wheelchairs. [To be achieved by 30/09/2025]

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/09/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	24/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/08/2025
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	Substantially Compliant	Yellow	20/08/2025

	and are available for inspection by the Chief Inspector.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	10/09/2025
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.	Not Compliant	Orange	20/08/2025
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	20/08/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape,	Substantially Compliant	Yellow	10/09/2025

	building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/09/2025
Regulation 31(4)	Where no report is required under paragraphs (1) or (3), the registered provider concerned shall report that to the Chief Inspector at the end of each 6 month period.	Not Compliant	Orange	20/08/2025
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.	Not Compliant	Orange	20/06/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	16/09/2025
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	Not Compliant	Orange	30/12/2025

	necessary, review and update them in accordance with best practice.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	10/09/2025
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	09/09/2025
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a	Substantially Compliant	Yellow	20/08/2025

	high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
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.	Not Compliant	Orange	14/09/2025
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	08/09/2025
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	Substantially Compliant	Yellow	10/09/2025

	residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/09/2025