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:	27 July 2026
Centre ID:	OSV-0000601
Fieldwork ID:	MON-0051035

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:	25

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 27 July 2026	16:45hrs to 20:00hrs	Breeda Desmond	Lead
Tuesday 28 July 2026	08:30hrs to 14:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

This unannounced inspection was conducted with a focus on adult safeguarding and reviewing the measures the registered provider has in place to safeguard residents from all forms of abuse. The inspector met with many of the residents living in the centre and spoke with seven residents in more detail to gain insight into their lived experience there. Residents spoke very highly of all the staff and the food served. The inspector spoke with two visitors who were very complimentary of the care in Castletownbere Community Hospital. They visited the previous 'all Ireland football final day' and said it was magic, the fun, craic and excitement, even though Kerry did not win, they were more than happy for Mayo to 'take Sam to the west'. They said they place was decorated with 'all sorts', there was a party atmosphere with food and beverages offered and the singing was wonderful.

Castletownbere Community Hospital is a residential designated centre providing 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 25 residents living in the centre at the time of this inspection. The inspector arrived in Castletownbere Community Hospital at 4:45pm on the first evening of the inspection. The evening meal was due to be served at 5pm, however, tables were not set for the meal, instead, trays were set for meals to be delivered to bedrooms. Three resident were in the day room awaiting to be returned to their bedroom, so when the inspector came on site, a further four residents were brought back up to the day room from their bedrooms. 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 sociable. Residents said that the food was gorgeous and that the fish is always beautiful. Later in the evening, residents were offered snacks and those in the day room all had hot chocolate which they really enjoyed. The inspector noted that residents had their breakfast either in bed or in their bedrooms' following which, staff provided personal care to residents.

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. While there was evening activities detailed of walks outside with staff, this was not implemented as all residents were routinely taken to their bedrooms following the afternoon activity, even though it was a lovely summers evening.

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.

The chapel was a beautiful peaceful space with stained glass windows and seating for residents. Residents reported that they visited the chapel as it was a lovely quiet space they enjoyed.

The centre was clean and appeared well maintained. There was directional signage to orientate residents and prevent confusion. Butterfly icons depicted the codes for exiting the building displayed following the findings of the last inspection which enabled visitors and residents to independently exit the building.

Corridors had lovely artwork displayed. 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. While there was a separate dining room beside the day room, this was seen to be unused. Staff set the tables in the day room for the main meal. While the hairdressers room was refurbished, it still remained un-opened since the previous two inspections.

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.

On day two of the inspection 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.

Appropriate signage was displayed on doors indicating rooms storing oxygen or where oxygen was in use. Rooms such as the sluice room and clinical medication storage rooms were secure.

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 unannounced inspection was undertaken to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations with a focus on safeguarding, and to follow up on the previous inspection judgements. Regarding findings of this inspection relating to safeguarding, improvement was noted in Castletownbere Community Hospital and while some supports were in place to enable residents have a good quality of life, improvement was required regarding affording residents' choice in their daily lives as many of the routines were staff-led and did not consistently ensure residents' autonomy.

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 management structure was enhanced with the appointment of a senior manager with responsibility for the centre named as a person participating in management; this resulted in the removal of the additional condition to the registration of the centre. The centre also has support from centralised departments, such as finance, human resources, fire and estates, and practice development.

The centre is registered to accommodate 31 residents, and there were 25 people residing in the centre at the time of inspection. Weekly and monthly quality and governance meeting are facilitated by the senior management team; additional meetings have been introduced to support persons in charge in community hospitals, and feedback from local management was that this was of immense collegial support. Senior managers have attended the centre since their appointment, and this was welcomed by the local management of Castletownbere Community Hospital, as it is in such a remote location.

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 demonstrated that a weekly analysis of key clinical performance indicators was completed, however, assessment of residents and their dependencies was inaccurate and did not reflect the true measure of residents' care needs. 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 institutional practices 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. Improvement was noted in staff training with mandatory training up to date for all staff including safeguarding and related topics. The duty roster showed there were adequate staff allocated on a

24hrs basis. Staff records were examined and vetting disclosures were in place for all staff; nursing registration certificates were evidenced for all nurses for 2026.

A review of the incident and accident records and the post falls review log showed these were comprehensively maintained. While on incident was not notified to the regulator as part of their statutory obligations, the issue was investigated, followed up and performance management implemented for staff involved. There was a complaints procedure displayed, however, it differentiated between formal and informal process which may be inaccessible for some people. Information relating to the Patient Advocacy Services was displayed and this was added to the complaints procedure during the inspection.

Schedule 5 policies and procedures required review to ensure they complied with specified regulatory requirements. Clarification was provided on inspection regarding information to be included in the NF39 quarterly returns regarding as required PRN medications, and the person in charge was grateful for this information. The service was not a pension agent for any resident.

Regulation 15: Staffing

A review of the duty roster demonstrated adequate staffing for the size and layout of the centre and the assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

Improvement was noted regarding staff training. All training was up to date with additional training scheduled to ensure training remained current. Additional training provided included medication management, supportive pathway with non-cognitive symptoms of dementia, the HSE IRESTORE early warning score to support residents to enable early intervention should their condition deteriorate for example.

Judgment: Compliant

Regulation 23: Governance and management

Some of the management systems in place were not sufficiently robust to ensure that the service provided is safe, appropriate, consistent and effectively monitored:

- there was a lack of oversight of the submissions of statutory notifications to the regulator; for example, there was a delay of 13 days submitting one NF06; delays in submitting two quarterly returns; one notifiable incident was also not submitted to the regulator,
- there was a lack of oversight of staff as some institutional practices were observed throughout the inspection such as all residents in bed or in their bedrooms following afternoon activities, and having their 5pm meal in their bedroom,
- some bedroom fire doors were observed to have small dust bins in the doorway to keep the door open a little which affected the efficacy of the fire protection systems – this was identified on the previous two inspections, however, to date, this had not been remedied,
- resident dependency levels were maintained as part of oversight of the service, however, these were seen to be inaccurate as they had identified all the residents as maximum dependency, but the actual dependency was - one medium, eight high and 16 maximum dependent residents, so assurances were not provided regarding the assessment of care needs
- there was a lack of oversight of safety checks as checks scheduled every half hour as part of a resident's safeguarding plan were not always adhered with,
- the complaints procedure differentiated between formal written and informal complaints and may not be easily accessible to some people.

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.

Most safeguarding concerns were identified as such; the inspector reviewed associated documentation and saw that these were comprehensively addressed and the appropriate referrals were made to ensure the safety and welfare of residents concerned.

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.

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. Some of the care documentation showed outstanding insight of residents' psycho-social needs with specialist interventions to support residents; however, 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 really good individualised detail to inform personal care, others did not. Staff demonstrated excellent knowledge of residents in their care, however, assessments and care plans did not consistently reflect this knowledge. 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.

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, some of these were excellent and they also identified the barriers to implementing a restraint-free environment for the resident, however, others did not have this detailed. Restrictive practices were being monitored, and it was identified that the centre did not have low low beds to trial alternatives to bedrail restrictive practice. This concern was placed on their risk register and the issue escalated to senior management. 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.

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. For example, a

pictorial alphabet chart formed part of one resident's care documentation. This alphabet chart demonstrated the finger strokes to spell out each letter on the resident's cheek to communicate with the resident.

Judgment: Compliant

Regulation 17: Premises

While assurances were provided on the previous inspection that a fit-for-purpose smoking shelter would be available for residents, this was not yet in place to ensure the safety and well-being of resident who smoked; they had no shelter for smoking when the weather was inclement.

Judgment: Substantially compliant

Regulation 26: Risk management

There were centre-specific risk management policies for the service. Separate risk registers were maintained which including risks associated with individual residents as well as clinical and non-clinical centre risks.

Judgment: 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:

- many of the care documents reviewed were not signed or dated by the staff completing the records in line with their policy
- one resident's significant medical history was not referenced in their mood and behaviour assessment; even though the resident had related concerns, the assessment did not acknowledge these as part of the their care needs to enable appropriate measures to be put in place to support the resident,
- while some controls were implemented to safeguard the resident, these were all clinical in nature and documentation did not consider any social intervention, despite this, staff spoken with detailed routine social activities to enhance the resident's quality of life,
- one resident's medication care documentation had not been updated following review by the GP with additional instructions to inform their care

- 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 sought. 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 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:

- nine of 25 residents had bedrails; it was explained to the inspector that there were no low low beds in the centre to trial a less restrictive option to bedrails, in accordance with national policy.

Judgment: Substantially compliant

Regulation 8: Protection

Action was required to ensure residents were safeguarded from institutional practices, as:

- at 4:50pm, there were just three residents in the day room. The staff had returned residents to their bedrooms following the afternoon music session. It was explained to the inspector that it was the routine that staff returned all residents to their bedroom. This institutional 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
- while safety checks were scheduled every half hour as part of a resident's safeguarding plan, this was not always adhered with, for example, there were no check from 2pm – 8:30pm on July 20th, no checks from 9am – 5pm on July 26th, and no checks from 6pm – 7:30pm July 27th.

Judgment: Substantially 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 were not offered choice to attend the dining room
- while there was an evening activities programme detailing walks outside with staff, this was not implemented as all residents were routinely taken to their bedrooms following the afternoon activity before their meal at 5pm, even though it was a lovely summer evening during the inspection,
- 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Castletownbere Community Hospital OSV-0000601

Inspection ID: MON-0051035

Date of inspection: 28/07/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

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

To comply with Regulation 23, the Person in Charge (PIC) and the PPIM (Person Participating in Management) have met in relation to strengthening governance, oversight and monitoring systems to ensure that regulatory, clinical and operational requirements are consistently met and effectively monitored. The PIC is clear in relation to her role and responsibilities.

A monthly PIC forum chaired by the PPIM is in place to discuss governance and risk.

Monthly SIMT (Serious Incident Management Team) meetings are in place to review category 2 incidents. This SIMT is chaired by the Operations Manager.

A Category 1 SIMT is in place chaired by the HOS (Head of Services).

There is an audit ICT system in place to support the implementation of clinical audit in Castletownbere Community Hospital. Clinical Audit Reports are available to the management team to aid oversight of the quality of care provided to residents. This includes care planning, clinical records and medication management.

There are arrangements in place for practice development to support the PIC and her team on an ongoing basis.

Statutory Notifications

The PIC will continue to review all incidents that meet the criteria for notification and ensure that statutory notifications are submitted to the Chief Inspector within the required timeframes. Responsibility for oversight of notifications is delegated to the

CNM2 during periods when the PIC is on leave or unavailable.

Completion Date: 26/08/2026

Residents' Rights, Choice and Daily Routines

The PIC has reviewed care practices and daily routines to ensure residents are supported to exercise choice and control over their daily lives, including decisions regarding activities, rest periods and dining experience. Staff are reminded daily at Safety Pause and throughout the day that residents must be encouraged and supported not to retire to their bedrooms following an afternoon activity session unless this reflects their expressed wishes, assessed needs or care plan. Residents' choices regarding dining arrangements will be respected and documented in their care plan. Residents' feedback on choice and quality of life will be sought through resident meetings, social and recreational audits, and residents' satisfaction audits. Results of audits findings will be actioned and reviewed by the PIC and all actions will be implemented where necessary.

Completion Date: 18/08/2026.

Fire Safety

All bedroom fire doors will continue to be checked daily to ensure they remain unobstructed and function as intended.

The funding for the maintenance cost of a swing-free device on some of the doors that allow residents to have their door slightly ajar has been approved by the Head Of Service and maintenance have confirmed that this work will be completed by the 18th September.

Compliance with fire door checks will be monitored by PIC/CNM2.

Completion Date: 17/09/26 and ongoing monitoring in place.

Clinical Assessment and Dependency Monitoring

Refresher training has been provided to nursing staff on the appropriate application of the Clinical Frailty Scale, Braden Risk Assessment Tool and Barthel Index. Nurses have reviewed the assessments to ensure the assessment outcomes accurately reflects the residents' current needs and are used to inform dependency levels, care planning and care delivery. Assessments will be reviewed following any significant change in a resident's condition. The PIC will complete regular audits of assessment documentation and dependency classifications to ensure consistency, accuracy and compliance with best practice, with corrective actions implemented where required.

Completion Date: 31/08/2026 and ongoing monitoring in place.

Safeguarding

Where half-hourly safety checks form part of a safeguarding plan, these are included as

a standing agenda item at daily handover meetings. The PIC will maintain ongoing oversight through regular review and audit of safety-check records to ensure safeguarding measures are implemented consistently and effectively. Any gaps identified will be addressed immediately and discussed with staff through supervision and team meetings.

Completion Date: 17/08/2026 and ongoing monitoring in place.

Complaints Management

The complaints procedure will remain readily accessible to residents, families and visitors. Staff have been reminded of their responsibilities regarding the receipt, documentation, investigation and management of complaints. The PIC will review complaints regularly to ensure complaints are managed within the required timeframes, complainants are kept informed throughout the process and learning arising from complaints is used to improve delivery service.

Completion Date: 27/08/2026 and ongoing monitoring in place.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A quotation for the installation of a permanent smoking shelter has been obtained.

The HSE South West Region is currently operating under Tier 4 cost containment controls. Given the level of expenditure proposed, funding approval has been escalated to the Regional Executive Officer and, where appropriate, onward to the HSE Chief Executive Officer.

The funding required to complete this work will need to be identified as part of the Region's capital allocation and approval is currently awaited for funding to support the 2027 capital works programme across the Region.

Once funding becomes available, the installation of a permanent smoking shelter will be prioritised. At present, it is anticipated that the earliest possible implementation date would be February 2027, subject to the necessary funding and approvals being secured.

In the interim, a temporary designated smoking area has been established for residents who wish to smoke. The temporary area has a cover that provides shelter from adverse

weather conditions and has a sand bucket to facilitate the safe disposal of smoking materials.

The Person in Charge (PIC), CNM2 and staff will continue to monitor the temporary smoking area to ensure it remains safe, accessible and suitable for residents' pending installation of the permanent smoking shelter.

The PIC will progress the permanent smoking shelter project once approval is received.

Completion Date: 28th February 2027.

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 plan documentation has been signed and dated by the staff, in line with the Castletownbere Community Hospital documentation policy. Residents' significant medical history has been referenced within mood and behaviour assessments, and relevant assessments have reflected the impact of medical conditions on identified care needs. Nursing staff will be reminded of this requirement at staff meetings.
Completion Date: 26/08/2026

In accordance with Castletownbere Community Hospital's Policy on the Provision of Social and Recreational Activities, Residents' preferences, participation levels and social interventions has been documented within their care plans and Therapeutic Recreation Activity Plans. All residents have been and will continue to be offered opportunities to participate in meaningful and appropriate social activities that support their wellbeing and quality of life.
Completion Date: 26/08/2026

Nursing staff have been reminded that medication-related care documentation must be reviewed and updated following any GP review, medication change or additional clinical instruction, in line with Castletownbere Community Hospital's Medication Management Guidelines.
Completion Date: 26/08/2026

Residents Care plans have been updated to ensure residents' wishes in relation to future and end-of-life care are clearly recorded.
Completion Date: 26/08/2026.

Staff identified as requiring additional support in completing assessments and care planning documentation will receive guidance from the PIC and CNM2.
Completion Date: 26/08/2026

Findings from care plan audits and assessment reviews, including identified gaps, actions and learning opportunities, will be discussed with nursing staff and included as a standing agenda item at Staff Nurse Meetings.

Commencement Date: 26/08/2026 and ongoing.

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:
To comply with Regulation 7, the PIC will continue to promote the use of the least restrictive alternatives and support the ongoing reduction of restraint practices.

A number of low-low beds will be precured to ensure that less restrictive alternatives are available and can be trialed where appropriate.

For each resident using bedrails, a comprehensive restraint assessment is completed and maintained.

Completion date February 2027

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Residents will continue to be supported to exercise choice in deciding where they wish to spend their time following activities and where they wish to have their evening meal. Residents may choose to remain in the day room, dining room or retire to their bedroom in accordance with their individual preferences.

Residents' choices regarding social engagement, activities and dining arrangements will be respected and facilitated by staff. These choices will be documented daily within residents' Therapeutic Activity Flow Sheets.
Completion Date:18/08/2026.

The PIC will ensure that all safeguarding measures identified within residents' safeguarding plans are implemented consistently and incorporated into the daily Safety Pause process. Required safety checks will be completed and documented at the prescribed frequency, including half-hourly observations where identified as part of a safeguarding plan.
Completion Date: 18/08/2026.

The PIC supported by CNM2 will check twice daily with nursing staff to ensure that all required observations, monitoring arrangements and safeguarding interventions have been completed and appropriately recorded.

Any omissions, delays or concerns identified through these reviews will be addressed immediately, with appropriate corrective actions implemented and discussed with relevant staff members. Compliance with safeguarding plans, safety-check requirements and residents' rights to choice will be monitored through regular audits and management oversight.

Completion Date: 18/08/2026.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To comply with Regulation 9, the PIC will ensure that residents' rights, choices, privacy, dignity and independence are promoted, respected and supported in all aspects of daily life.

The PIC has reviewed current practices to ensure that nursing staff have documented residents' choices regarding where they wish to have their breakfast each day. The CNM2 supported the PIC with this work.

The residents were asked where their preference is for having their meals and many of the residents communicated that they wished to have their meals in the day room. Specifically, the residents stated that they would prefer to remain in the day room because they don’t like having to move to another room to have their meals.

Reference to this is documented in their respective care plans.

Where a resident chooses to get out of bed and have breakfast in the dining room or another communal area, this choice is facilitated and documented in accordance with the resident's preferences, abilities and assessed needs.

Staff have been reminded that residents have the right to make decisions about their daily routines, including meal locations, social engagement and participation in activities, and that these choices must be respected and supported wherever possible.

All staff have undertaken the Safeguarding Module on HSEland.

SAGE Advocacy services are available to Castletownbere Community Hospital.

Completion Date: 18/08/2026

PIC will introduce a monthly audit of residents' choices to ensure that preferences relating to meals, activities, daily routines and social engagement are clearly documented and consistently respected in practice.
Findings from these audits will be reviewed at staff meetings, and any identified areas for improvement will be addressed promptly with relevant staff members.

Completion Date: 28/09/2026

The PIC will review the availability, suitability and condition of privacy screens throughout Castletownbere Community Hospital to ensure they support residents' privacy and dignity while remaining safe and compliant with Infection Prevention and Control (IPC) requirements.
Any privacy screens purchased or replaced will be suitable for residents using mobility aids or wheelchairs and, where practicable, will promote residents' independence through ease of use.

Completion Date: 10/09/2026

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/02/2027
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social	Substantially Compliant	Yellow	26/08/2026

	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.			
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	26/08/2026
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	28/02/2027
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	18/08/2026
Regulation 9(1)	The registered provider shall carry on the business of the designated	Substantially Compliant	Yellow	18/08/2026

	centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	28/09/2026
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	10/09/2026