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:	Unit 1 St Stephen's Hospital
Name of provider:	Health Service Executive
Address of centre:	St Stephens Hospital, Sarsfield Court, Glanmire, Cork
Type of inspection:	Unannounced
Date of inspection:	29 May 2026
Centre ID:	OSV-0000715
Fieldwork ID:	MON-0050646

About the designated centre

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

Unit 1 is a dementia specific unit situated within the 117 acres of grounds at St Stephen's Hospital, Sarsfield's Court, Glanmire, Co Cork. It is situated approximately two kilometres from Glanmire village and seven kilometres from Cork city. It is a single storey detached building and is registered to accommodate 16 residents. Residents' accommodation comprises of one single bedroom, and the rest of bedrooms are three-bedded rooms. Assisted showers toilets and bathrooms are across the corridor. Communal space includes a dining room and sitting room and a sensory room. Residents have access to an enclosed garden with panoramic views of the valley and countryside. All bedrooms open onto a veranda. The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18, long-term residents and palliative care to older people with dementia. The centre provides 24-hour nursing care and medical care is available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Friday 29 May 2026	09:40hrs to 14:45hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This risk inspection was conducted in response to information that the person in charge of the centre had been absent for an extended period. Therefore, the Chief Inspector had concerns pertaining to the governance and management of the service. There were nine residents living in Unit 1 St Stephen's Hospital on the day of this inspection. All residents living in the centre were diagnosed with a cognitive impairment and therefore, some were unable to speak with the inspector. Throughout the day the inspector spent time observing residents' daily lives and care practices in the centre, to gain insight into the experience of those living there. The inspector did not have the opportunity to meet with any visitors on the day as none were present in the centre.

Unit 1 St Stephen's Hospital is single storey designated centre for older people registered to provide care to 16 residents. It is a one storey detached premises situated on an extensive 117-acre site. The centre is co-located on a large campus with other Units, collectively known as Sarsfield Court. All residents in the centre live in multi-occupancy three bedded rooms, which are located along a single corridor spanning the length of the building. There is one single bedroom in the centre, however, this is kept to care for a resident at the end of their life or if it was required to isolate a resident due to an infection. Bathroom and shower facilities are shared and situated along the main corridor, across from the bedrooms. The inspector saw that these bathroom and shower facilities, apart from one, were kept locked throughout the day and staff opened them with a key as required. Doors to the external secure garden to the side of the premises also remained locked. Discussions with staff indicated that there was not a specific reason for this and a review of records found that there were no associated risks documented or being monitored, in relation to these practices. The inspector also noted that some bathroom doors had the inside locks removed, therefore, residents could not lock the door while using these facilities. These were institutionalised practices and did not respect residents' privacy and dignity and are detailed under Regulation 9; Residents Rights.

Walking around the centre the inspector observed that bedrooms were more reflective of a hospital environment as opposed to a home. For example, there were minimal personal items such as family pictures and memorabilia around residents' beds and privacy curtains were disposable. The inspector noted that in one bedroom there were no lockers or wardrobes for one of the residents and was informed that these had been removed and were being stored elsewhere. Although observations of the inspector were that staff were kind and compassionate towards residents, care delivery was based on a medical model where people were verbally referred to as patients, not residents in their own home.

The inspector met with the six staff on duty on the day, half of whom were employed via an agency. From a review of rosters and from discussions with the

management team it was evident that maintaining staffing resources had been challenging, which resulted in inconsistent staffing levels. The impact for residents was that they were not always being cared for by staff who knew and understood their care requirements and their behavioural support plan. This is further detailed under Regulation 23 of this report.

The inspector spent time observing the dining experience for residents. In total six residents attended the dining room which was seen to be encouraged by staff. However, the inspector saw that food did not look appetising or fresh, particularly modified, and textured diets. The inspector was informed that food was prepared in the campus main kitchen and then frozen. This food was delivered daily and cooked from frozen in the kitchen in the centre. Food such as bread, milk, butter, jam and yogurts were maintained in the centre's kitchen, however, the inspector noted that there was not fresh food such as fruit available. Although the inspector saw that there was a sufficient number of staff available to support residents at the mealtime, this was seen to be task orientated as opposed to a social experience for residents. For example, some staff were observed standing while assisting residents with their meals and the medication trolley was brought in when residents arrived to the dining room. These and other findings in relation to the provision of food are further detailed under Regulation 18: Food and Nutrition.

Staff were observed throughout the day being kind to residents and for residents who required increased monitoring and support, this was seen to be adhered. Staff were observed to sit with some of the residents in the main sitting room and read the paper to them. Two residents attended day care facilities on the main campus four days per week. Although there was an ample number of staff to provide social stimulation on a one-to-one basis for residents, there was not variety to residents' day. For example, the activities schedule on display had the same activities on every day which comprised of chats with staff and garden walks and at the weekend it stated there was sensory music played. The inspector observed minimal use of the garden on the day of this inspection although the weather was dry and warm. This is actioned under Regulation 9, Residents Rights.

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

Capacity and capability

Findings of this unannounced risk inspection were that the governance and management systems in the place were ineffective to ensure a safe and quality service was delivered to residents. Significant action was required concerning several regulations, including governance and management, residents' rights,

protection, and the notification of statutory incidents, as outlined in the report. An urgent action was issued to the provider in relation to food and nutrition.

The registered provider of the centre is the Health Service Executive (HSE). Since the last inspection of September 2025, there had been change in the governance and management of the centre. Specifically, there had been a change in a person participating in management, who had been appointed to this role in March 2026. However, the Chief Inspector had not been appropriately informed via the statutory notification process, as required, of this change. The person in charge is a registered nurse and works full-time in the centre. The person in charge is responsible for overall governance and reports to a General Manager in the HSE. As mentioned in the first section of this report the registered provider had failed to notify the Chief inspector as legally required, of the absence of the person in charge for over 42 days. These findings are further detailed under Regulation 32 and registration Regulation 6.

There were an appropriate number of staff working in the centre on the day of this inspection. The person in charge was supported by a clinical nurse manager who worked full time in the centre. However, as referenced earlier in the report there was agency staff covering a large amount of both the day and night shifts. Although the Clinical Nurse Manager, who took responsibility for the roster, endeavoured to request the same agency staff work in the centre the inspector was informed that this was not always possible. A review of rosters indicated that there were some days and nights where the centre was being operated by agency staff alone. The three registered nurses (RGNs) and two healthcare assistants (HCAs) available to the roster was not adequate to cover all shifts in the centre. Coupled with this, the provider did not have procedures in place for the recruitment and retention of suitable staff and had not recruited RGNs or HCAs in five years. These findings are actioned under Regulation 23: Governance and Management.

Incidents occurring in the centre were recorded via the HSE National Incident Management System (NIMS). From a review of records of incidents occurring in the centre the inspector found that incidents as set out in 7(1) of Schedule 4 had been reported to the Chief Inspector as required. However, a written report of the quarterly incidents for the period of January-March 2026 had not been provided as required. This is further detailed under Regulation 31: Notification of Incidents. The inspector reviewed the complaints log and found that all verbal and written complaints had been well documented and investigated in line with the complaints policy and procedure of the centre. The provider displayed the complaints procedure prominently in the reception area and there was a complaints management policy. However, these documents required to be updated, as referenced under Regulation 34.

All staff were facilitated to attend up-to-date mandatory training which included annual fire safety, safeguarding residents from abuse and safe moving and handling procedures. Some staff working in the centre had recently attended training in caring for residents at the end of life. Notwithstanding the provision of training by

the provider, findings of this inspection were that the principles of training were not effectively implemented and monitored, as actioned under Regulation 16.

Communication systems with regards risk and incidents occurring in the centre were found to be not effective to ensure that senior managers had effective oversight of the service. Although there were monthly governance meetings taking place, these took place within the mental health services on the campus. A review of records of the last three meetings evidenced that these meetings primarily related to issues pertaining to the North Cork Mental Health Services and there was limited reference to the designated centre for older people. From a review of incident records and via conversation with management it was evident that four safeguarding incidents had not been communicated to senior management. This finding is further detailed under Regulation 23.

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider had not notified the Chief Inspector of changes to a person participating in management. This must be submitted in writing within 28 days, as per the requirements of the regulation. This was a repeated area of non-compliance as it had also been found on inspection of April 2025 that the registered provider had not notified of a change to the governance structure.

Judgment: Not compliant

Regulation 16: Training and staff development

Although mandatory training was up to date for staff working in the centre findings of this inspection were that further action was required to ensure they were effectively supervised and that they implemented the principles of training into practice with regards to the use of restraint, person centred care delivery and promoting residents' rights.

Judgment: Substantially compliant

Regulation 23: Governance and management

Significant action was required in relation to the governance and management of the service evidenced by the following findings:

- The registered provider had failed to notify the Chief inspector of the absence of the person in charge as per the requirements of the regulations.

- The governance structure had changed with the appointment of a new general manager who was to be named as a PPIM. This had not been appropriately notified to the Chief Inspector as required by the regulations.
- There was inadequate monitoring of risk in the centre. For example, the risk register had not been updated since 2024 and did not contain risks associated with staffing resources and complex admissions.
- Although there were adequate resources provided to the centre in terms of staffing numbers there was an over reliance on agency staff. The registered provider had not recruited a new member of staff to work in the centre for approximately five years. A review of rosters evidenced that on some days and nights agency staff was operating the centre.
- Findings of this inspection were that safe systems were not in place underpinning staff recruitment to ensure that residents were safeguarded. Specifically, for residents requiring enhanced staff supervision the inspector was not assured that staff who were allocated to care for the resident were knowledgeable regarding the specific care and behavioural support plan in place to support the resident. The impact of this was that other residents living in the centre were not safeguarded from abuse.
- The system for incident reporting within the centre was not sufficiently robust. Findings of this inspection were that there was not a system in place to notify incidents occurring in the centre when the person in charge was absent. This resulted in a delay in reporting quarterly incidents as required by the regulations. This was also a finding on a previous inspection of the centre.
- Although there were monthly governance meetings taking place these related to services under the remit of North Cork Mental Health Services. A review of minutes for monthly meetings found that there was not a representative from Unit 1 at these meetings for the last two months. Therefore, specific incidents which had occurred in the centre and risks associated with the operational management of the centre were not referenced, reported or addressed. This system was not effective to ensure that senior managers had oversight of the service.

Judgment: Not compliant

Regulation 31: Notification of incidents

Incidents set out in paragraph 7(2) of Schedule 4 had not been provided via a written report to the Chief Inspector for the period from January 2026- March 2026. This related to the number of restraints in use in the centre and the death of a resident.

Judgment: Not compliant

Regulation 32: Notification of absence

The registered provider had not given notice in writing to the Chief Inspector of the absence of the person in charge from the designated centre for a continuous period of 42 days.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure that the complaints management system met the requirements of the regulations, evidenced by the following findings:

- The policy in place did not reflect the current complaints officer and review officer and the policy was expired since January 2026.
- The complaints process on display in the centre did not provide sufficient detail with regards to how to make a complaint and it was not in an accessible format, to inform a person on how to make a complaint.

Judgment: Substantially compliant

Quality and safety

Findings of this inspection were that the inadequate governance and management arrangements place, as referenced in the first section of this report impacted on the delivery of a safe and quality service to residents. Significant action was required pertaining to resident's rights, food and nutrition, the use of restraint and protection which are detailed under the relevant regulations in this section of the report.

Care planning documentation was available for each resident in the centre, as per regulatory requirements. A pre-admission assessment was completed prior to admission to ensure the centre could meet the residents' needs. Care plans reviewed were updated four monthly and some contained detailed information specific to the individual needs of the residents and were sufficiently detailed to direct care. However, some improvements were required in to ensure all information contained was accurate to care delivery, which is further detailed under regulation 5 of this report.

Residents were provided with a good standard of evidence-based health and nursing care and support. Residents had timely access to a consultant who was based on

the campus and visited the centre weekly. Residents also had good access to other allied health professionals such as speech and language therapists, a dietitian and specialist medical services such as community mental health services as required. There was a low incidence of pressure ulcer development in the centre.

Residents' nutritional and hydration needs were assessed and closely monitored in the centre via monthly weights and the use of a validated malnutrition tool. Notwithstanding these findings, action was required pertaining to the way food was served and the availability of fresh food in the centre.An urgent action plan was issued to the registered provider, following the inspection, requiring them to review the staffing levels in the centre and to ensure that they were appropriate to meet the needs of the residents. The registered provider submitted a response within the requested time line, and provided assurances to the Chief Inspector, that these findings would be addressed. This is further detailed under regulation 18: Food and Nutrition.

The provider had admitted residents with complex care needs, including individuals requiring dedicated one-to-one support for behavioural and psychological symptoms associated with their diagnoses. However, the assignment of staff unfamiliar with residents' exhibiting responsive behaviours led to safeguarding risks for others in the centre.

Staff were observed to be courteous and kind towards residents throughout the day. However, inspector found that residents' rights were not always upheld in the centre as detailed under Regulation 9 and referenced in the first section of this report.

Regulation 18: Food and nutrition

Action was required pertaining to food and nutrition, evidenced by the following findings:

- Food served at lunchtime did not appear wholesome or nutritious, particularly textured and modified diets. Food was delivered to the centre frozen in aluminum disposable containers and heated in the centres kitchen. This food was then plated from these containers in the dining room in front of residents. The inspector was informed that food was cooked twice a week in the main campus kitchen and frozen for use throughout the week.
- There was a not a sufficient choice of nutritious and wholesome snacks easily available to residents such as fresh fruit. Due to the model of food delivery there was also limited opportunity for residents to have home baked produce such as scones and soups.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

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

- Communication care plans for residents were found to lack detail in relation to the supports required for each resident and details in relation to methods they use for communication.
- Responsive behaviour assessments and care plans were not all sufficiently detailed to direct care delivery.
- Although validated assessment tools were being used to assess clinical risk the findings of these were not always being reflected in residents care plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were reviewed by a medical practitioner, as required or requested. Arrangements were in place to ensure residents had timely access to health and social care professionals for additional professional expertise. There was evidence that recommendations made by professionals had been implemented.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

As found on previous inspections of the centre the use of restrictive practices in the centre was not in line with best practice evidenced by the following findings:

- The use of bedrails in the centre was almost 50 percent and there was not always evidence that alternatives had been trialled. From a review of records it was documented that these were allocated due to residents requests. However, some of these residents, due to their cognitive impairment were unable to consent to bedrails.
- There was restricted access to toilet facilities and the external garden. These staff practices were found to be overly restrictive. These were not identified as restraints within the centre and were not documented on the centres risk register.
- The system of the allocation of staff with up to date knowledge and skills to respond to residents with responsive behaviors is actioned under Regulation 23.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had failed to implement effective systems to safeguard residents from abuse, evidenced by the following findings:

- Where safeguarding risks were identified in the centre, the safeguarding measures put in place by the provider, specifically the supervision arrangements were not effective. Therefore, the systems failed to protect residents, as evidenced by the continuance of the safeguarding risks to residents.
- A number of incidents where residents were negatively impacted by the responsive behaviours of another resident had not been recognised as safeguarding issues and therefore had not been investigated and managed in line with the provider's safeguarding policy. A safeguarding plan was not put in place when indicated.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector was not assured that residents rights were being promoted in the centre, evidenced by:

- The social care needs of residents did not receive adequate attention to ensure that they were adequately stimulated and had variety to their day. This was also a finding on previous inspections of the centre. The activities programme was reviewed and was found to be very limited.
- A review of documentation found that residents or their nominated representative were not always consulted about operations of the centre. This did not respect residents rights.
- The absence of locks on the shared bathrooms doors did not ensure that residents privacy and dignity was respected.
- The location of televisions in multi-occupancy rooms, which were positioned above the door frame made access difficult for residents.
- The removal of a residents locker and wardrobe from their bedroom and the rationale for this as explained to the inspector did not provider assurances that residents civil rights were respected.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 6: Changes to information supplied for registration purposes	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of absence	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 18: Food and nutrition	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Unit 1 St Stephen's Hospital OSV-0000715

Inspection ID: MON-0050646

Date of inspection: 29/05/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 6: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: The provider will ensure that all documentation in relation to PPIM and PIC is submitted in line with HIQA regulations. As the nominated PPIM is still awaiting confirmation of Garda Vetting an application for change of PPIM until this is received was submitted on 16/07/2026 The registered provider acknowledges that they had not notified the Chief Inspector of changes to a person participating in management nor had they notified the Chief Inspector of the absence off the PIC as required under Regulations 6(1) and 6(2). The provider will ensure that they will comply through weekly communication between the PIC and PPIM ensuring the Chief Inspector is notified of any changes as required going forward in the manner and timelines outlined under these regulations ***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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Registered Provider has commenced a review of all restraints and restrictive practices that were observed during Inspection to ensure a comprehensive, human rights-based assessment and approach is in place. This includes full MDT review of the use of bed rails for clients who cannot consent. In addition each Resident will have	

dedicated Key Workers to ensure consistent person centered care delivery. This will be completed by 10/07/2026

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 acknowledges its failure to notify the Chief Inspector of the absence of the PIC in line with their obligations. The Registered Provider has put more frequent engagements with the PIC, CNM2 and PPIM to ensure any notification as required is completed within the timeframe. The registered provider acknowledges that they had not appropriately notified the Chief Inspector of changes to the person participating in management – the outstanding paperwork in respect of the PPIM was submitted with the exception of Garda Vetting which has been processed but awaiting confirmation of same. The Registered Provider acknowledges that the Risk Register did not reflect updating, however, Risk Assessments had been reviewed but this had not been reflected on the Register. This has been rectified and the Risk Register is now up to date (03/06/2026). In relation to Rostering of staff the Registered Provider is committed to ensuring consistent staffing, and is reviewing rosters to ensure appropriate skills and experience mix are evident on all shifts. The Registered Provider has attempted to recruit staff to the Centre, however they have been unsuccessful (recruitment of nursing most recently was attempted in February 2026, and HCA in May 2026). The Registered Provider is working with experienced regular Agency staff to commit to shifts to ensure consistent staffing.

To ensure that all staff who are allocated to care for each resident are knowledgeable regarding the specific care and behavioural support plan in place to support the resident, Key Workers will be appointed on each shift and in the event new staff commence, there will be a detailed briefing of their Residents ensuring the Residents Care Plan and Preferences are known and to ensure each Resident is Safeguarded

The Registered Provider acknowledges that the Inspection found insufficient reporting of Incidents. To ensure all incidents are reported in an appropriate and timely manner the PIC and CNM2 have committed to ensuring that the PPIM is made aware of any incident irrespective of category as soon as is practical to do so – this includes contacting the PPIM outside of office hours to ensure no delays.

It is acknowledge that Governance Meetings which occurred were in conjunction with colleagues from Mental Health Services. To ensure Robust Older Persons Governance and compliance, a Governance Group has been established for the Centre with MDT representation and will occur on a Monthly basis from July 2026 onwards.

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The Registered Provider acknowledges that it failed is its requirement to notify the Chief Inspector as required under paragraph 7(2) of Schedule 4. This has now been rectified. As outlined this will be prevented going forward through weekly engagement between CNM2, PIC and PPIM.	
Regulation 32: Notification of absence	Not Compliant
Outline how you are going to come into compliance with Regulation 32: Notification of absence: The Registered Provider acknowledges its failure to notify the Chief Inspector of the absence of the PIC in line with their obligations. The Registered Provider has put more frequent engagements with the PIC, CNM2 and PPIM to ensure any notification as required is completed within the timeframe.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The Policy has now been updated. Policies will be discussed as a standing item on the Monthly Governance Groups Meeting to ensure full compliance going forward. Visible signs informing Residents and their Families of the complaints process are on display in the Centre to ensure this is easily accessible and available.	
Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
As outlined in the Registered Providers Urgent Compliance Plan submitted 9th June 2026, we are committed to ensuring fresh, wholesome, nutritious food with sufficient variety is available to our Residents each day. In addition to the detail included in the Providers Urgent Compliance Plan, signs are being placed throughout the centre as prompts encouraging residents to request snacks, drinks etc. whenever they wish for same - this will be completed by 10/07/2026

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 actions which were noted in the Inspection report in relation to Individual Care Plans have been addressed. Any assessment tools which had been used are now reflected in each residents care plan. As each Care Plan is reviewed this action will be repeated to ensure all detail in respect of the Residents communication, behaviours and preferences are sufficiently detailed.

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:
Of the residents where bedrails were in use, two of whom had requested these are deemed to have capacity and therefore they are in use in line with their will and preference. Two residents whereby bedrails are in use are not deemed to have capacity and the Registered Provider has requested a full MDT review of these Residents to determine if these are required to ensure the safety of the Resident, or, if alternatives such as low low beds would provide same levels of safety. Updated Risk Assessments in relation to these two residents will take place following review.
The Registered Provider had the key pad access to the Garden deactivated to enable free movement to and from the Garden on 24/06/2026.

The Registered Provider has ceased completely the practice of locking doors accessing toilet facilities – all staff have been informed by the PIC of this. Furthermore, the Registered Provider has requested for dual side opening locks to be put in place on each toilet to ensure each Resident who is capable of utilising the toilet alone is provided with

the requisite dignity & privacy, whilst ensuring in case of emergency staff can access the Resident in a timely manner – this will be completed in 20/07/2026.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Each Key Worker at handover and the commencement of shift will be briefed by the PIC, CNM2 or Staff Nurse in relation to the identified safeguarding Risks in respect of their Residents. Safeguards which have been put in place for the protection of Residents particularly regarding Individualised Supports on a one to one basis will be strictly adhered to for all specified times. All Staff will be reminded of their requirements and responsibilities to Residents by the PIC under Safeguarding Vulnerable Persons at Risk of Abuse and this will also be as Standing Item on the Monthly Governance Group Meeting.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The ensure the Social Care needs of the residents are being met, the Provider explored external providers and are awaiting them to advise of availability. However, the Provider has received agreement with Staff in Valley View Day Care that they will attend the Centre on a weekly basis, and in addition, each Friday a member of the Occupational Therapy Department will be on site both of which will work on physical movement, Creative Expression, cognitive stimulation, and social connection of each Resident. 2 residents who currently attend Valley View on a daily basis will continue to do so. Daily activities currently include games, gardening, music therapy, life story reminiscence, make up sessions for female residents, attendance at mass. Furthermore a member of the Occupational Therapy Department who attends Unit 1 has commenced coaching a Health Care Assistant (HCA) to assist going forward. The activities nurse attends Unit 1 weekly to provide one to one and group Sonas. An activity folder to support the HCA doing the activities with the residents has been created, the folder will include activities that the residents or their family members have identified that they enjoy to ensure they are individualised and client centred. A bird bath has recently been acquired and once secured in place bird watching will form part of the activities. The PIC & PPIM will ensure that residents or their nominated contact are kept updated about any developments within the Centre once any decisions regarding the Centre are

made.

Dual Side Opening Locks are being installed to ensure privacy and dignity are respected

The Wardrobe which had been removed has been replace with a larger unit on coasters to ensure the Residents clothes and items are available to him at all times whilst ensuring safety of the Resident and their personal items.

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
Registration Regulation 6 (3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the centre) within 28 days of the change and supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of any new person participating in the management of the designated centre.	Not Compliant	Orange	16/07/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Substantially Compliant	Yellow	10/07/2026

	appropriate training.			
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	09/06/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	09/06/2026
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Not Compliant	Orange	09/06/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	10/07/2026
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation	Not Compliant	Orange	08/07/2026

	to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.			
Regulation 32(1)	Where the person in charge of the designated centre proposes to be absent from the designated centre for a continuous period of 42 days or more, the registered provider shall give notice in writing to the Chief Inspector of the proposed absence.	Not Compliant	Orange	08/07/2026
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	30/06/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with	Substantially Compliant	Yellow	08/07/2026

	the resident concerned and where appropriate that resident's family.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	20/07/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	10/07/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	16/07/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	10/07/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is	Not Compliant	Orange	10/07/2026

	reasonably practical, ensure that a resident may undertake personal activities in private.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/07/2026