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:	20 July 2026
Centre ID:	OSV-0000715
Fieldwork ID:	MON-0051101

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:	8

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 20 July 2026	10:45hrs to 16:30hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

This unannounced one-day risk inspection of Unit 1 St Stephen's Hospital was carried out by one inspector, seven weeks after a previous inspection in May, 2026. This purpose of this inspection was to ensure that the provider was taking action to address the significant areas of non-compliance identified on the previous inspection of the centre, which found that the Health Service Executive (HSE), was not compliant with seven regulations and had ineffective governance and management systems.

There were eight residents living in the centre on the day of this inspection and eight empty beds. The management team informed the inspector they were closed to admissions and the last resident admitted to the centre was in March 2026. Throughout the day the inspector spent time observing residents' daily lives to gain an insight into the experience of those living there. The inspector met and greeted all residents living in the centre. Two residents told the inspector they were "treated well" and "staff were good", however, most residents were unable to speak with the inspector. The inspector did not have the opportunity to meet with any visitors on the day as there were not any 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 detached premises co-located on a large campus with other Units, known as Sarsfield Court. Collectively the campus is vast and extensive measuring approximately 117-acres. The centre is managed Monday to Friday by a Person in Charge, supported by a Clinical Nurse Manager, both of whom operate in a supernumerary capacity. Outside these hours, including nights and weekends, management responsibility is delegated to a manager within the Mental Health Services on the campus.

The inspector arrived to the centre mid-morning. The inspector observed in the main sitting room, to the left of the entrance, three residents were relaxing with two members of staff. These staff members told the inspector they were working with an agency, one had been attending the centre for a few weeks and the other for a few months. The inspector observed kind interactions with staff and the residents where the ladies had their make-up done and they were also doing hand massages with the residents. The inspector saw that a programme of individual activities was developed for each resident, with the support of the occupational therapist, since the previous inspection. Staff spoken with stated that having these activities plans, which were stored in a folder, were very beneficial. Staff were seen to positively engage with residents throughout the day, taking them for walks into the garden, reading to them and playing games. Two of the eight residents went to the day care services on the campus on the morning of this inspection.

Residents were accommodated in multi-occupancy three-bedded rooms located along a single corridor that runs the length of the centre. The centre also had one

single bedroom, which was reserved for residents requiring end-of-life care or isolation due to an infection. The inspector saw that some new pictures had been hung in bedrooms since the previous inspection and wardrobes were now available in all residents' bedrooms for their personal belongings. However, as found on the previous inspection the location of televisions above the door frame made visibility and access difficult for residents. The inspector was informed that new televisions had been ordered.

Shared bathroom and shower facilities were located along the main corridor opposite the bedrooms. The inspector observed that these bathroom and shower facilities were no longer locked from the outside. Internal locks had been installed to promote residents' privacy and dignity, in response to findings of institutional practices identified during the previous inspection. Some residents were observed using these facilities independently on the day of the inspection. The inspector also noted that the doors to the secure garden area were unlocked and remained open throughout the day, facilitating residents to access this area unrestricted. Residents were observed to enjoy the garden on the day of this inspection, and one resident was seen to water the plants independently.

Although there is a kitchen within the centre, food is prepared in the main campus kitchen and delivered to the centre a few times a day. The inspector was invited to visit the campus kitchen during the inspection which was located a few minutes away by foot. The inspector also spent time observing the lunchtime meal and improvements were noted in residents' dining experience since the previous inspection. Residents were encouraged and supported to attend the dining room, and the processes for serving and reheating food had been reviewed and enhanced. The inspector observed that meals were now plated in the centres kitchen. Residents were offered a choice of fish or baked ham and spoke positively about the taste of the food. Food appeared wholesome and nutritious. Staff were observed sitting with residents who required assistance and engaging positively with them during the meal. However, while residents were offered a choice of fish or baked ham, the inspector noted that residents prescribed modified-texture diets were not routinely provided with the fish option when requested. As a result, these residents effectively had only one menu choice available each day, unless staff specifically requested a fish alternative from the kitchen. This finding is addressed under Regulation 18: Food and Nutrition.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This unannounced risk inspection was conducted to assess the registered providers compliance with the regulations and to follow up on the findings of the previous

inspection which found that ineffective monitoring and oversight systems, together with insufficient staffing resources, posed risks to the delivery of safe, effective, and high-quality care for residents. Following the inspection of May 2026, the provider was required to attend a warning meeting to discuss the findings of concern and the registered provider's failure to notify the Chief Inspector of changes in centre management, absence of the person in charge, the staffing resources, the provision of food and the extent to which residents' rights were being upheld. This inspection found that while the provider had taken some measures to address the findings of the previous inspection there continued to be a failure in the ensuring effective governance and management systems were in place as non-compliance persisted in the areas of residents' rights, supervision of care delivery, staffing and governance and management. These findings are outlined under the relevant regulations within this report.

The registered provider of the centre is the Health Service Executive (HSE). There was a clearly defined management structure in place. The senior management team with responsibility for the centre included the Head of Service for Community Health Area 4, a General Manager for Older Persons, as well as a person in charge. The person in charge works full time in the centre and has responsibility for the daily operational management of the service. The person in charge reports to a General Manager in the HSE, who the inspector was informed, was available for consultation and support daily. The person in charge was supported by a clinical nurse manager who worked full time in the centre and deputised in their absence. Since the previous inspection the registered provider had notified the Chief Inspector of changes to information supplied for registration purposed as per requirements of the regulations. This related to a change in a person participating in management. However, at the time of this inspection all information had not been received to progress this, which is actioned under Regulation 6 of this report.

There were an appropriate number of staff working in the centre on the day of this inspection. Specifically, there were six staff members allocated to care for eight residents. The person in charge worked from 9am to 5 pm, a clinical nurse manager was working from 8am to 8pm and a registered nurse was assigned to work from 8am to 8pm. There were also three healthcare assistants working from 8am to 8pm. However, the provider did not have procedures in place for the recruitment and retention of staff and had not recruited RGNs or HCAs in five years. In total there were three registered nurses (RGNs) and two healthcare assistants (HCAs) available to the roster which was not adequate to cover all shifts in the centre. As a result there was an over reliance on agency staff. As found on the previous inspection a review of rosters indicated that there were some nights where the centre was being operated by agency staff, who were not familiar with the residents living in the centre.

The provider had failed to honour the commitments given in their compliance plan, in response to the poor findings of the previous inspection in relation to the allocation of resources and risk management. This registered provider stated that they would ensure there was consistent staffing and would review rosters, to ensure appropriate skill mix and experience on each shift. However, this was not effectively implemented and there was inadequate oversight of staff allocation and supervision,

particularly at night by management. These findings are further detailed and actioned under Regulation 15: Staffing, Regulation 16: Training and Staff Development and Regulation 23: Governance and Management.

Records were seen to be maintained in the centre and stored adequately. The inspector reviewed a sample of residents contracts of care and these met regulatory requirements. Incident records were being maintained and all incidents had been reported as required to the Chief Inspector since the previous inspection.

As found on the previous inspection the management systems were not effective in ensuring that the service was safe, appropriate, and subject to adequate oversight. This included shift handover communication systems, risk management, ensuring there were accurate personal evacuation plans for residents and the managements oversight of night-time staffing arrangements. These findings are discussed in further detail under Regulation 23.

The inspector was informed that new communication arrangements had been introduced since the previous inspection through monthly multidisciplinary meeting which were planned to take place in the centre. Attendees included the General Manager, Consultant Psychiatrist, Person in Charge, Occupational Therapist, and Area Mental Health Nursing Lead. The inspector was informed that the first meeting had taken place on-site in mid-July and focused on matters relating to residents living in the centre, including incidents and complaints. However, the minutes of this meeting were not available for review on the day of the inspection. The Person in Charge committed to providing these following the inspection.

Registration Regulation 6: Changes to information supplied for registration purposes

Although following the findings of the previous inspection the registered provider had notified the Chief Inspector of the changes to a person participating in management via an NF31, not all required information had been received to progress this notification at the time of this inspection.

Judgment: Not compliant

Regulation 15: Staffing

The provider had failed to ensure that the skill mix of staff was appropriate in the centre at night time. Specifically, the provider had failed to adequately address the allocation of appropriate night staff to manage and operate the centre and to ensure they possess the appropriate knowledge, training and skills to meet the needs of residents living in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The registered provider failed to ensure appropriate supervision and support arrangements by senior clinical managers for agency staff assigned to operate and manage the centre at night. Some of these allocated staff were unfamiliar with residents care requirements. This did not protect and promote the care and welfare of residents.

Judgment: Not compliant

Regulation 23: Governance and management

As found on the previous inspection of the centre, significant action was required pertaining to the governance and management of the centre evidenced by the following findings:

(1) The registered provider had failed to ensure that resources within the centre were planned and managed in a manner that supported the delivery of person-centred, effective, and safe services. For example, the allocation of agency nurses to manage and operate the centre at night posed a potential risk to residents. A review of duty rosters found that over 50% of night shifts since the previous inspection had been allocated to two agency staff. Also on multiple occasions over the previous seven weeks, an agency nurse had been assigned responsibility for the management and operation of the centre from 8pm to 8 am, despite having no prior experience working in the centre.

(2) The management systems in place to monitor the quality of the service were not effective to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, evidenced by the following findings:

- The registered provider had failed to implement effective oversight of staff rosters since the previous inspection to ensure that staff allocated to work with residents at night were familiar with their care requirements. The provider had stated in their compliance plan following the inspection of May 29th 2026 that they would ensure that staff that were allocated to care for residents were knowledgeable regarding specific care and behavioral support plans.
- The communication systems in place to ensure that information relating to residents was available to the nurse responsible for the unit at night were inadequate. These systems consisted of a night-shift handover and a night-duty work schedule; however, a review of the documentation found that it contained insufficient information to support the safe delivery of care.

Specifically, the records reviewed included limited details regarding residents' medical histories, mobility support needs, levels of dependency, and any history of responsive behaviours. As a result, the inspector was not assured that nurses unfamiliar with the centre had access to the information necessary to provide safe and appropriate care.

- The Registered provider has failed to assess, manage and respond to known risks within the centre in relation to the availability of staffing resources and the use of agency staff. Risk management systems were not effectively monitored or implemented. The centre's risk register did not contain risks in the centre such the allocation of staff of agency staff at night to manage and operate the centre. Therefore, there was a failure to recognise the potential impact on the care of residents, supervision of staff, medication management and fire safety. This meant that actions to mitigate and manage risks to residents had not been identified.
- A summary of residents Personal Emergency Evacuation Plans (PEEP) were in place for staff to access in the event of a fire emergency. However, some of these records were not kept up-to-date and referred to multiple evacuation methods for residents. This could cause confusion in the event of an emergency. The management staff were requested to update these records immediately before completion of the inspection.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract of care agreed with the registered provider. A sample of contracts viewed contained included the services provided and fees to be charged. Contracts also included the room to be occupied. The contracts were seen to meet the requirements of legislation.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed the incidents that had occurred since the previous inspection which were documented on the HSE National Incident Management System. The record of incidents occurring in the centre was well maintained. All incidents had been reported in writing to the Chief Inspector, as required under the regulations, within the required time period.

Judgment: Compliant

Quality and safety

Ineffective monitoring and oversight systems, together with insufficient staffing resources, as described in the first section of this report continued to pose risks to the delivery of safe, effective, and high-quality care for residents. Action was required in relation to resident's rights, food and nutrition and the use of restraint.

Improvement were noted in the provision of food at mealtimes and in the dining experience for residents since the previous inspection. The policy had been updated to reflect changes in practices. Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required. There were adequate numbers of staff available to assist residents with their meals. Assistance was offered discreetly, sensitively, and individually. Residents with needs for special, modified, and fortified diets were provided with meals and snacks prepared as recommended. However, the inspector was not assured that residents prescribed modified diets had a choice made available at mealtimes. This is further detailed under Regulation 18: Food and Nutrition.

The inspector observed staff engaging with residents who exhibited behavioural and psychological symptoms of dementia. Engagement was respectful and non-restrictive. Care plans were seen to outline de-escalation techniques, and ways to effectively respond to behaviours. Where bed rails were used, there was supporting risk assessments, consent obtained and multidisciplinary team involvement. However, the inspector was not assured that alternatives were trailed such as half bed rails, which were available in the centre. This finding is actioned under Regulation 7. Care planning documentation was available for each resident in the centre, as per regulatory requirements and had been reviewed following the findings of the previous inspection.

The previous inspection identified that the provider had not implemented adequate systems to safeguard residents from abuse. Specifically, appropriate supervision arrangements were not consistently in place where safeguarding risks had been identified. During this inspection, the inspector reviewed this finding and found that the provider had addressed this non-compliance by ensuring that residents received appropriate supervision in accordance with their assessed needs. This action had contributed to a reduction in safeguarding incidents within the centre and had reduced the associated risk to residents.

As referenced earlier in the report the provider had reviewed and enhanced the activities available for residents in response to the findings of the previous inspection. Activities were observed to be provided to residents on the day of the inspection with the support of health care staff. Resident had access to an independent advocacy service. However, as found on the previous inspection the inspector was not assured that residents or their nominated representative was not

always consulted about the operations of the centre. This did not respect residents' rights as detailed under Regulation 9.

Regulation 18: Food and nutrition

Residents prescribed modified consistency diets did not have a choice of meal on the day of inspection. The inspector observed a resident request the fish option but was informed that it was not available for their prescribed diet, and that only bacon was available. A review of the menu and discussions with the catering team confirmed that fish options could be ordered from the campus kitchen with 45 minutes' notice. However, it was evident that it was not routine practice within the centre to offer residents prescribed textured diets a choice of two meal options.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The Clinical Nurse Manager had direct responsibility for quality assuring all residents care plans and had put systems in place to ensure they were updated. Comprehensive nursing assessments were in place using a range of validated tools to assess risk of developing pressure ulcers, weight loss, and falls. They were reviewed four monthly or if there were changes to a residents condition.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The principles of a restraint-free environment were not always promoted in the centre. Three residents (37.5%) were allocated bed rails on the day of this inspection. However, from discussion with staff it was evident that alternatives which were available in the centre, such as half bed rails were not trialled to ensure the least restrictive option was used and residents independence was promoted.

Judgment: Substantially compliant

Regulation 8: Protection

Improvements had been made in relation to safeguarding practices within the centre. Supervision arrangements were strengthened to ensure that, where safeguarding risks had been identified, residents were supported by staff who were familiar with their behavioural support plans during the day. However, as actioned under Regulation 23, there were ineffective communication methods to ensure staff were aware of residents behavior support plans at night.

Judgment: Compliant

Regulation 9: Residents' rights

As found on the previous inspection action was required pertaining to residents rights evidenced by the following findings:

- Systems to ensure that residents were consulted about the operation of the centre were not adequate. There had been no residents' or family meetings held since December 2025, limiting opportunities for residents and their representatives to provide feedback and contribute to service development. In addition, a review of records found that where family members had raised queries or concerns regarding accommodation arrangements, there was not information provided to the inspector to demonstrate that these matters had been acknowledged, monitored, or addressed. As a result, the inspector was not assured that residents and their representatives were meaningfully consulted with or that their views informed the operation of the centre.
- The location of televisions in multi-occupancy bedrooms, which were positioned above the door frame did not support residents having access to this facility.

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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

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

Inspection ID: MON-0051101

Date of inspection: 20/07/2026

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**
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 submitted requisite paperwork for change in PPIM 16/07/2026. This was further submitted by email 24/07/2026 following an Urgent Warning meeting with the HIQA Deputy Chief Inspector, Regional Manager and Inspector	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider is committed to ensuring appropriate staffing of the center to ensure they possess the appropriate knowledge training and skills to support the Residents. The Provider has reviewed Rosters and is committed to ensuring that directly employed staff are on each shift. A weekly audit has commenced of rosters (each Tuesday in advance) jointly by PPIM and PIC to ensure full compliance with Regulation 15. 2 samples of this are attached to this submission. Any noncompliance is identified at this point and rectified. Copies of each audit are attached to each Roster Week in Unit 1.In addition, a staff member who had tendered their resignation has now revoked same and has advised that they will remain working in Unit 1 until the Unit closes. Furthermore, a HCA who has worked across Older Persons services and is currently working in Home Support will be inducted into Unit 1 to provide further support to our Residents and ensure compliance with Regulation 15. This staff member will commence week commencing 5th October.	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
In addition to the current access arrangement to both the CNM2 on site at night for St Stephens Campus and the On Call ADON, the provider ensures that the CNM2 on duty will call to Unit 1 at night.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider is committed to ensuring appropriate staffing of the center to ensure they possess the appropriate knowledge training and skills to support the Residents. The Provider has reviewed Rosters and is committed to ensuring that directly employed staff are on each shift.

The provider acknowledges the Inspectors review of handover documentation particularly for the night shift and the provider is reviewing this to ensure that all required information in respect of each resident is contained within this.

The Provider conducted a review of the Risk Register and Risks relating to agency staff as identified by the inspector- These identified risks have been updated and included in the risk register. A risk assessment specific to agency staff has been completed.

PEEPs as acknowledged by the Inspector were updated before the Inspection was completed.
A weekly audit has commenced of rosters (each Tuesday in advance) jointly by PPIM and PIC to ensure full compliance with Regulation 15. 2 samples of this are attached to this submission. Any noncompliance is identified at this point and rectified. Copies of each audit are attached to each Roster Week in Unit 1.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
All residents have the right to choose their preferred meal, whilst options are placed on a menu for Residents to choose from, requests made by residents outside of this are honored within 1 hour of their request.

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:
Use of restraints as identified by the Inspector are as a result of 1 Resident requesting same as this is their will and preference. The 2nd resident using cot sides has been risk assessed and deemed requiring cot sides for their safety. The 3rd resident previously using cot sides have been risk assessed and cot side use discontinued presently. A trial is being undertaken on the use of a low-low bed, and floor mat.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Written communication was issued to Residents and their families (and staff) on 28th July 2026 by the General Manager advising Residents and their families of the Providers intention to submit a NF35 to the Regulator. This letter advised Residents, families and staff that the General Manager would be on site the week of 3rd August 2026 to meet with each of them. All Residents and Families have identified their preference for their next home.

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 15(1)	The registered provider shall ensure that the number and skill	Not Compliant	Orange	01/09/2026

	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.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/08/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	13/08/2026
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.	Not Compliant	Orange	30/08/2026
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	31/08/2026
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in	Substantially Compliant	Yellow	24/08/2026

	a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	13/08/2026
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	13/08/2026