



**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:	Mount Alvernia Hospital
Name of provider:	Health Service Executive
Address of centre:	Newberry, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	16 April 2026
Centre ID:	OSV-0000723
Fieldwork ID:	MON-0048874

About the designated centre

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

Mount Alvernia is set on a rural site, southwest of Mallow town in Co. Cork. The building was originally built as a community hospital in the 1950s with accommodation and facilities laid out along a single corridor on four floors. Facilities on the ground floor include administration offices, the main kitchen facility and a dining area for staff. There is also a chapel and a hairdressing facility for residents to use on this floor. Resident accommodation is laid out over the top three floors. Information as set out in the statement of purpose describes St Camillus' unit, on the first floor, as providing accommodation in four single and five twin bedrooms. Communal areas on this floor include a dayroom and dining room and a separate room to receive visitors in private. On the second floor, Clyda unit, provides four twin and three single bedrooms as well as one three-bedded ward. Communal areas on this floor include a day room and dining area. Avondhu unit on the third floor provides focused care for residents with a cognitive impairment or dementia, and this unit is accessible via a keypad secure system. Accommodation here includes six single and three twin bedrooms. There is also a sitting room and dining area as well as a small separate room for residents to receive visitors should they so wish. There are no en-suite bathroom facilities in any of the rooms and all residents share toilet and shower facilities on each floor. The grounds provide residents with opportunities for exercise and recreation with outside seating, paved walkways and an orchard. The centre provides long-term residential care for residents over the age of 18 requiring continuing care in relation to a range of needs including chronic illness, dementia and enduring mental health issues.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	34
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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
Thursday 16 April 2026	09:30hrs to 18:30hrs	Erica Mulvihill	Lead
Thursday 16 April 2026	09:30hrs to 18:30hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This was an unannounced inspection over one day by two inspectors of social services. Residents in Mount Alvernia told inspectors that they were very happy living in the centre and were complimentary about staff and the care they received. Inspectors spoke to a large number of residents throughout the day, but spoke to six in detail. Residents who were unable to communicate with the inspectors were observed to appear comfortable and content with their environment.

The inspectors arrived to the centre unannounced at 9:30am. They followed the centres sign in procedures and were met by the person in charge. Following an opening meeting, the inspectors were accompanied on a walk around the centre and observed the care environment and the lived experience of residents in the centre. Staff demonstrated that they knew residents very well and one resident commented that they felt "staff were like extended family", with another resident commenting that they felt they were so well cared for and respected by staff and management.

Mount Alvernia is situated in a rural setting near the town of Mallow in North Cork. The building is an old hospital style building with infrastructural challenges associated with its age. However, the provider had committed to a programme of works on the resident floors with bedroom and bathroom upgrades observed in some areas. The hospital chapel which was a beautiful quiet space for residents was on the ground floor and residents informed the inspectors that they had mass said there weekly by a local parish priest who acted as chaplain for the centre also.

Accommodation for residents was located over the top three floors; St Camillus on the first floor, Clyda on the second floor and Avondhu on the top floor. The centre had capacity for 40 residents but 34 residents were living in the centre on the day of the inspection. A number of the twin bedrooms were single occupancy on the day of the inspection as the inspectors were informed by the person in charge and observed the layout of some of these rooms were not suitable as twin accommodation. Bedrooms in the centre did not have ensuite bathrooms; however adequate numbers of shared toilets, bathroom and shower rooms were available on each floor. Notwithstanding this, one communal shower room was out of order and unable to be used by residents. This was a repeat finding since the inspection in November 2025. This will be actioned under Regulation 17: Premises.

Bedrooms were seen to be clean and tidy and items of personal significance to residents were on display on walls or on vanity units in their rooms. New directional signage was erected on bedroom doors to enable residents to locate their bedrooms more easily. Communal spaces on each floor comprised of a day room and a dining room. These areas were seen to be in use by residents throughout the day of the inspection. The third floor had two small dining rooms as well as a dayroom. These

spaces were cosy, homely rooms where residents could sit, relax and enjoy the company of others or watch TV as per their preferences.

A small number of residents were observed coming in and out of the centre and were using the grounds to go for a walk around, where some residents who smoked were observed to go to the designated smoking area throughout the day of the inspection.

In the morning, a volunteer attended the centre to work with the activities staff member to provide an arts and crafts session where a large number of residents attended to enjoy painting or knitting and some residents were observed to enjoy the company of others. A recent outing to Blarney Woollen mills was a highlight for some of the residents in the centre and more outings for the summer time were being planned by the staff.

Mealtimes were a sociable experience in the centre. Meals served to residents looked very appetising and residents were very complimentary about the quality of food served in the centre. One resident was very complimentary about the new chef stating " everything they make is delicious, no complaints at all".

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 impacted on the quality and safety of the service being delivered.

Capacity and capability

This one day unannounced inspection was carried out by two Inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, as amended. While the inspectors found that some of the findings of the previous inspection had been actioned, findings of this inspection were that the governance and management systems in the centre required strengthening to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored.

Mount Alvernia Hospital is a designated centre for older persons that is owned and operated by the Health Service Executive (HSE) who is the registered provider. The centre was operated through the governance structures of the mental health services for Cork and Kerry Community Healthcare. The inspector found that the lines of accountability and responsibility for the service needed strengthening. The person participating in management (PPIM) had departed from their role in February 2026 and whilst a new person had been nominated by the provider for the role, required information in relation to this was not received by the Office of the Chief

Inspector at the time of the inspection. This is actioned under Registration regulation 6: Changes to information supplied for registration purposes.

There was evidence of clinical auditing ongoing in the centre. A review of these audits detailed a high level of falls had occurred in the centre in recent months. The provider had an action plan in place in relation to falls and when a fall would occur, risk reduction measures were applied locally and the person in charge referred the fall event to a Serious incident management team (SIMT) who would review the incidents and identify any recommendations to reduce occurrences. There was good evidence of the centres engagement in this process and inputting recommendations into practice thereafter. This was a positive finding.

An annual report on the quality of the service had been completed for 2025 which had been done in consultation with residents and set out the services level of compliance as assessed by the management team.

The centre has a full time person in charge who was supported by an assistant director of nursing along with a team of clinical nurse managers (CNMs) assigned to each floor, staff nurses, health care assistants, household and catering staff and a team of administration staff. On the day of the inspection, the inspectors found there was adequate staffing numbers to meet the assessed needs of residents having regard for the size and layout of the centre. Staff working in the centre were observed to be kind, respectful and well known to the residents they cared for.

Records of meetings with all staff groups were available for review. Whilst a number of discussion points were observed, it was not evident that staff were facilitated to raise any concerns about the quality and safety of care and support provided to residents in these meetings. This is actioned under Regulation 23: Governance and Management.

A new training matrix system for the centre had been implemented which allowed the person in charge to easily retrieve information on dates training was required and to be able to plan future dates of training to ensure all staff were up to date with training for their specific roles and responsibilities. Training records for the centre were reviewed and were up to date.

In general, records were well maintained in the centre, however, records which had resident specific information were found by the inspectors in a box inside an unlocked press accessible to all staff, in a store room on the corridor. This is a repeat finding from the previous inspection and will be actioned under Regulation 21: Records.

Whilst there was a low level of complaints in the centre, those that were available for review were managed appropriately in line with the centres complaints policy. The complaints procedure was displayed for residents to view on corridors in the centre.

The inspectors saw that most incidents that had occurred in the centre were notified within the required timeframes to the Office of the Chief inspector, however, the person in charge did not supply a written report to the Chief Inspector of all deaths

which occurred in the centre as set out in schedule 4 of the regulations. This is actioned under Regulation 31: Notification of Incidents.

The centre was located within a five storey building, with residents bedrooms all located at first, second and third floor. Ground floor comprised primarily of staff offices and ancillary accommodation, the kitchen and residents' chapel, hair salon and visitors room. The lower ground floor had the laundry, plant rooms and storage rooms. In April 2021, the provider had arranged for a fire safety risk assessment for the centre, which was reviewed again in July 2022. Most actions from that assessment were documented as completed, however there was no sign off on work completed. The inspectors observed some of those actions to be outstanding. This is further discussed under Regulation 28: Fire Precautions.

Regulation 15: Staffing

The number and skill mix of staff was appropriate for the size and layout of the building and was adequate to meet the assessed needs of the 34 residents living in the centre on the day of the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The provider was committed to providing ongoing training to staff. On the day of the inspection, staff were appropriately trained and the training records reviewed showed evidence of ongoing refresher training planned. Staff were knowledgeable of their roles and responsibilities.

Judgment: Compliant

Regulation 19: Directory of residents

The provider had a directory of residents available for review which contained the required information as set out in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

Safe storage of records in the designated centre required action as follows:

Records that had personal resident information and information regarding the running of the centre were not securely stored in the centre. There were observed in an unlocked press in a store room accessible to all staff. This did not comply with legislation in relation to data protection. This is a repeat finding from the previous inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management systems in place required were not effective to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored in particular in relation to the following:

- systems in place to ensure oversight of Fire precautions were not sufficiently robust and required action as outlined under Regulation 28: fire precautions
- the provider had failed to ensure required documentation in relation to the notification of change of Person participating in management (PPIM) was submitted to the Office of the Chief Inspector.
- staff meetings were held but did not demonstrate that staff were facilitated to raise any concerns regarding the quality and safety of care provided. The meeting minutes demonstrated a managerial agenda without capturing the opinions of staff attending the meetings.
- oversight of risk was not robust, the banister to the central stairs presented a risk of falls; the height of the banister was not risk assessed to determine what controls were required
- oversight of the maintenance of the premises required improvement
- oversight of the storage of records was not robust

From a walkthrough of the centre, the inspectors identified that the floor plans against which the designated centre was registered, was not a true reflection of the footprint of the centre. For example, the following were not shown correctly;

- the layout of the laundry. It was also shown at the same level as the ground floor plan, but it was actually situated at a level below
- the configuration of the photocopy room, store, lift and rear entrance lobby did not align with the floor plans
- the door between the entrance hall and the reception was not shown on the plans

At lower ground floor, rooms used for the running of the designated centre were not shown or annotated in red on the floor plans, including main plant room, general store and maintenance room.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A review of a sample of contracts of care showed that contracts had the required information in relation to room numbers, additional fees and type of accommodation as set out in the regulation. Some residents who had requested to change rooms, had evidence of consultation and choice being offered detailed in their contract of care.

Judgment: Compliant

Regulation 31: Notification of incidents

Action was required to ensure the provider shall at the end of every quarter in relation to the occurrence of an incident set out in schedule 4 submit a notification to the office of the chief Inspector. For example:

On review of care records, it was noted that residents who had passed away in the centre in the last quarter of 2025 were not notified to the office of the chief inspector as per the regulation.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had an accessible and effective procedure for dealing with complaints, which included a review process. The required timelines for the investigation into, and review of complaints was specified in the procedure. This was displayed in the centre on each floor. A record of complaints was maintained in the centre, in line with regulation requirements.

Judgment: Compliant

Regulation 4: Written policies and procedures

Generally, the policies in the centre were well maintained and contained up to date information. However, two policies required under Schedule 5 of the regulations were out of date and required to be updated.

Judgment: Substantially compliant

Quality and safety

Overall, residents in Mount Alvernia were supported to experience a good quality of life which was respectful of their wishes and preferences. Their needs were being met through timely access to healthcare services and opportunities for social engagement. Findings on this inspection were that the provider had addressed some of the findings of the previous inspections, however, inspectors found that additional improvements were required particularly due to the age and era of the building.

Notwithstanding the positive findings highlighted through the report, further action was required as described under Regulation 17: premises, Regulation 28: Fire precautions and Regulation 5: Individual assessment and care plans.

In terms of the premises, residents' bedroom accommodation generally met regulatory requirements in terms of space and storage provision. Within the east escape stairs, there was evidence of a leak and black mould. The person in charge confirmed this would be cleaned on the day of inspection. There were horizontal cracks visible to the walls to which the engineer had applied tape to track if the cracks were increasing.

While some of the actions relating to the premises from the previous inspection had been completed, not all commitments by the provider in their compliance plan had been met. These are explored under Regulation 17: Premises.

This inspection found there was mixed levels of compliance relating to fire safety. The improvements brought about from the fire safety risk assessment, improved fire containment and the means of escape from the building. Higher risk rooms had been provided with enhanced fire containment. The fire compartments were identified by management to the inspectors. One of the fire compartment boundaries at third floor was located between a small dining room and the main sitting room. There was an opening without a door on this boundary, which meant that the fire compartments were not effectively separated from each other. This created a risk that residents may be moved through the compartment boundary into an area which was not protected from the fire.

The records for the emergency lighting and the fire detection and alarm systems showed they were serviced as required. Deficits identified with the emergency

lighting system were actioned and appropriately signed off. The periodic inspection report for the electrical installation was due in the weeks following the inspection.

In general, fire doors were to a good standard, however some deficits were observed where maintenance was required. The inspectors saw some areas where fire doors were not fitted to risk rooms at ground floor. This is explored further in Regulation 28: Fire Precautions.

The provider had arrangements in place for assessing residents' needs and requirements prior to admission to the centre. The inspectors reviewed person-centred care plans based on validated risk assessment tools. Notwithstanding these areas of good practice in care planning, some gaps were observed in the sample of care plans reviewed, which will be outlined under Regulation 5: Individual assessment and care plan.

A restraint-free environment was promoted in the centre and the levels of restrictive practice such as bedrails were monitored regularly. Alternative measures to bed rails such as sensor alarms were assessed and used where necessary. Consent was obtained when restraint was in use and care plans were in place.

The inspectors found that residents' rights were upheld in the centre. Staff were respectful and courteous towards residents. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents' meetings and twice yearly resident satisfaction surveys. Residents' privacy and dignity were respected. The centre had religious services in-house weekly and access to pastoral care for residents when required. Residents could communicate freely and had access to independent advocacy services if requested. A robust activity schedule was in place which enabled residents to have great access to social engagement.

The activities coordinator took residents to town to go shopping when they wished to do so and arranged external volunteers such as arts and crafts volunteers and musicians to ensure a robust activity schedule was in place. Residents had access to visitors who were welcomed to the centre freely without restriction. The residents were enabled to meet together daily to say the rosary. Many residents liked to attend this session from all areas of the centre.

Regulation 17: Premises

A review of the premises confirmed that the following areas did not meet the requirement of Schedule 6 of the regulations and required action:

- all resident sinks in the designated centre did not have a means to retain water to enable residents to be able to attend to their personal hygiene needs in their bedrooms.
- a communal shower room was unable to be used by residents as the shower was broken and required repair (repeat finding)

- Call bells were not evident in some toilets and some communal parts of the centre such as visiting rooms on the ground floor and the chapel.
- Some grab-rails in shower rooms had rust on them and appeared corroded and required to be replaced
- Within some single rooms, the privacy curtains remained from when they had been two bedded rooms. The person in charge committed to reviewing with the resident and removing them if not required
- The laundry chute which allowed laundry to reach the basement laundry area from all floors appeared unclean.
- Within the east escape stairs, there was evidence of a leak and black mould. This was cleaned during the inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors reviewed the findings from the previous inspection and the provider had addressed those actions. This inspection included a focused review of fire safety and the findings were that action was required by the provider to ensure adequate fire precautions.

The provider was not taking adequate precautions against the risk of fire as hoist batteries were being charged inappropriately in a store room against combustible items and dryers in the laundry were observed to have a build up of lint in the filter and were being cleared only at the end of the day, posing a risk of fire.

The arrangements for providing adequate means of escape were not adequate and required assessment, for example;

- The provision of emergency lighting along external escape routes was not adequate to safely guide occupants from the exits to a place of safety if the power in the building failed
- At first and second floor, there were two single bedrooms at each level which opened directly onto the stairs enclosure. This impacted the escape for the residents of those four rooms, but also the protection of the escape stairs from a fire that may start in one of those rooms.
- Escape corridors at ground floor, where residents circulate to the hair salon and visitors room, were not adequately fire protected from all risk rooms.
- The door swing at a final exit door opens out across a change in floor level. This poses a risk of fall where the step would not be readily apparent when opening the door in an emergency
- In the event that a fire prevented the use of the central stairs, staff would be required to assist residents down four flights of stairs and a further extended distance at lower ground floor to reach and exit; this route was extensive and

burdensome for staff and residents. The person in charge indicated that this would be reviewed to determine if there were safe alternative strategies

The provider is required to have their competent person review the containment measures as assurance was required in relation to the fire compartments at third floor between the dining and day room and at ground floor in the reception area. Similarly, further assurance was required at lower ground floor to the enclosure of the laundry chute. Some risk rooms at ground floor level were not fitted with appropriate fire rated doors, such as store rooms and offices.

The service report viewed for the fire curtain at basement included actions which had not been completed. There were some maintenance deficits to fire doors which required action, such as gaps,

In terms of evacuation, the inspectors reviewed the evacuation drills completed in the centre; these included a combination of in house drills and those supervised by an external third party. The in-house drills did not contain sufficient information to demonstrate that the evacuation procedure was fit for purpose. They precluded the number of residents, staff and where residents were evacuated to. The inspectors observed the configuration of the door leading to the central stairs to be narrow and there was no drill to show this route was suitable. Following training, the provider had procured evacuation pads as a further aid for vertical evacuation. These were stored in an adhoc manner in store rooms and were not readily accessible nor known by all staff where they were located, but were identified in residents' personal emergency evacuation plans (PEEP) for use. These were relocated to a more suitable location during the inspection; further drills were required to confirm that staff knew how to use these and that they fit along the escape routes..

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that care plans were up to date to reflect the changing needs of the residents in the centre and directed staff in care practices. For example:

- on one residents nutritional assessment, it stated a resident was not diabetic which was contrary to other documentation which stated the resident was an insulin dependant diabetic therefore could not assure that up to date information was available to inform care and direct care staff. The dietary requirement information in the pantry did not have information in relation to this resident being on a diabetic diet.
- one resident who had their resuscitation status updated by their General Practitioner (GP) had a note made in their care plan but this information was not informed to the daily progress notes to direct staff.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had very good access to medical assessment and review by their General Practitioner (GP). A range of allied health professionals were also available to residents such as a physiotherapist, dietitian, speech and language therapy, chiropody, tissue viability nursing and palliative care. These services were all available based on referral and evidence of these referrals was available on the day of the inspection.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Where restrictive practice measures were in place, such as the usage of bedrails, the inspector found that residents were assessed appropriately and it was used in line with national policy. On review of the resident files, there was evidence of consistent monitoring and review of these restraint practices. Staff were up to date with training in responsive behaviours. The inspector observed staff providing person centred care and support to residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) in a kind and respectful manner.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were provided with the opportunity to be consulted about the organisation of the designated centre by participating in residents' meetings. Staff demonstrated an understanding of residents rights and supported residents to exercise their rights and choices. Some residents for example like to go on day trips to town with support from the activities coordinator. There was a schedule of activities available for residents that they could participate in, in accordance with their interests and capacities. Residents had access to TV, radio and papers. Advocacy services were available also to residents.

Judgment: Compliant

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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 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mount Alvernia Hospital OSV-0000723

Inspection ID: MON-0048874

Date of inspection: 16/04/2026

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A review of all areas has been completed & all records containing resident's personal details are now stored to comply with legislation in relation to data protection.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure that all documentation in relation to the change of person participating in management will be submitted to the Office of the Chief Inspector in a timely manner. The PPIM had to resubmit their Garda Vetting as there was an error in the Garda Vetting Application. The PPIM will submit Garda Disclosure once received. Staff meetings will be more detailed to include discussion of the agenda. The Banister to the central stairs will be raised to ensure safety of the residents, staff & visitors. A maintenance plan has been put in place to address required improvements in the premises. Oversight of the Fire Precautions are being addressed. It is proposed to move the 2 bedrooms on the first and second floor that open directly onto the stairs enclosure into one of the compartments & move 2 low risk rooms into this area on both floors. New maps will be drawn up to address the issues highlighted during the inspection & the Laundry will be shown on a separate map from the Ground Floor. The plant room & General store & maintenance room will also be shown on the new maps. All Fire recommendations are noted in Regulation 28 .	

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

Regulation 31: Notification of incidents	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The Provider will ensure that at the end of every quarter submit notification of any deaths within the hospital.

Regulation 4: Written policies and procedures	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

All schedule 5 policies are up to date.

Regulation 17: Premises	Not Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

The communal shower in Avondhu ward is being replaced .The provider will undertake a risk assessment to consider if a sink stopper is suitable to be used in the sinks in Mt Alvernia. The Provider will provide sink stoppers for the residents deemed to be not at risk

A review of the call bells has been completed & all necessary replacements are in place
The Grab rails have been replaced as required.

The PIC will ensure that the privacy curtains that are not necessary will be removed after discussion with the residents.

The Maintenance department will provide cleaning for the Laundry chute.

The fire escape stairwell has been cleaned & repaired & will be monitored.

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Hoist Battery charging arrangements have been reviewed and hoist batteries will no longer be charged in storage areas or adjacent combustible materials. A designated charging arrangements will be maintained and included in local fire safety checks. • Laundry fire safety arrangements have also been reviewed & the dryer Lint Filters will be checked & cleaned at defined intervals during the day. • A competent fire safety consultant will complete a review of the fire actions within the centre. This review will include the previous safety risk assessment, actions recorded as completed, outstanding fire safety actions and specific fire safety matters identified during the inspection. • The provision of external lighting will emergency lighting will be assessed. Any required additional emergency lighting will be installed, tested and certified. • The means of escape arrangements will be reviewed, including the bedrooms opening directly onto stair enclosures, the final exit door opening across a change in floor level, the adequacy of alternate escape routes where the central stairs may be unavailable, and the suitability of the narrow route leading to the central stairs on the third floor for evacuation purposes. Where required, interim control measures and permanent remedial works will be identified and completed. • Fire containment measures will be reviewed at the third-floor compartment boundary, the ground floor reception area, the lower ground floor laundry chute enclosure and ground floor risk rooms. Any required work to provide or improve fire and smoke separation will be added to the fire safety action plan and completed through a prioritised work programme. • A fire door and risk-room door review will be completed. Fire door defects, including excessive gaps, poor closing, damaged seals or unsuitable doors, will be recorded and remediated. • The outstanding actions identified in the basement fire curtain service report will be reviewed and completed. Evidence of service, repair and completion will be retained in the fire safety register. • Evacuation arrangements will be strengthened. Fire drills records will be revised to include the fire scenario, location, number of residents involved, number and grade of staff present, evacuation route used, equipment used, destination or safe placement area, time taken, learning identified and actions required. • Evacuation pads will be stored at stairwell exits in clearly identified and readily accessible locations. Staff will be briefed on their location and use, and practical evacuation drills will be completed to confirm that staff can use the equipment safely and that the equipment is suitable for actual escape routes. • Residents Personal Emergency Evacuation Plans will be reviewed to ensure they reflect resident dependency, mobility, staffing arrangements, evacuation equipment, escape routes and safe placement arrangements. • A regulation 28 fire safety action will be maintained .The tracker will identify each action, the person responsible, target completion date, interim control measures,	

evidence required and close –out status. Evidence of completion will be retained in the centres fire safety register, including competent person reports, inspection records, certificates, service reports, photographs, and updated drawings, staff briefing records, training records, fire drill records and action close- out documentation.

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 residents care plans have had a further review & are now up to date

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.	Not Compliant	Orange	12/12/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	29/06/2026
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	29/06/2026
Regulation 28(1)(a)	The registered provider shall take adequate	Not Compliant	Yellow	31/08/2026

	precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/08/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/08/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/08/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire	Substantially Compliant	Yellow	31/08/2026

	alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	29/06/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/08/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/08/2026
Regulation 31(3)	The person in charge shall	Substantially Compliant	Yellow	29/06/2026

	provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	29/06/2026
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 the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	29/06/2026