



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Ospideal Pobal Chorca Dhuibhne (West Kerry Community Hospital)
Name of provider:	Health Service Executive
Address of centre:	Mail Road, Dingle, Kerry
Type of inspection:	Unannounced
Date of inspection:	13 May 2026
Centre ID:	OSV-0000569
Fieldwork ID:	MON-0050531

About the designated centre

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

Ospidéal Pobal Chorca Dhuibhne (West Kerry Community Hospital) is a designated centre which is located on the outskirts of the coastal town of Dingle, Co. Kerry. It is a single storey facility that also accommodates the primary care public health service and community care day centre. It is registered to accommodate a maximum of 46 residents. The entrance to the centre is called An Croí (The Heart) and this is an expansive space with seating areas for residents and visitors to gather. The main dining room, oratory, quiet room and activities room are located here. The designated centre is set out in two wings: Ionad Bhreannainn with 22 beds and Ionad Eibhlis with 24 beds. Bedroom accommodation comprises single, twin and multi-occupancy four-bedded rooms, all with hand-wash basins; some bedrooms have en-suite facilities of shower, toilet and hand-wash basin while others share shower and toilet facilities. Each unit has a dining area, two day rooms and occasional seating areas by the nurses' station and along corridors. Residents have access to paved enclosed courtyards with seating and garden furniture. Ospidéal Pobal Chorca Dhuibhne provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, respite, convalescence and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43
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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
Wednesday 13 May 2026	13:30hrs to 19:00hrs	Ella Ferriter	Lead
Thursday 14 May 2026	08:00hrs to 15:00hrs	Ella Ferriter	Lead
Wednesday 13 May 2026	13:30hrs to 19:00hrs	Caroline Connelly	Support
Thursday 14 May 2026	08:00hrs to 15:00hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This unannounced two-day inspection of West Kerry Community Hospital was carried out by two inspectors, seven weeks after a previous inspection in March 2026. The purpose of this risk 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 HSE was not compliant with eight regulations and had poor oversight of the care of residents.

To gain an insight into life in the centre over the two days, the inspectors spoke with residents and observed the practices of staff and management. From what residents told the inspectors, and from what was observed it was evident that the residents living in the centre were content and happy with the care they received. Residents told inspectors that staff were lovely and kind to them. Some residents commented that there had been more life in the centre over the past few weeks and more things to do. The inspectors had the opportunity to meet with six visitors over the two days and they praised the team of staff and the welcome they received when they visited.

West Kerry Community Hospital is a designated centre for older people situated in the town of Dingle in West Kerry. The centre is in a Gaeltacht area, and for some residents living in the centre Irish was their first language. There were 43 residents living in the centre on the days of this inspection. Residents were accommodated on two units called Ionad Bhreannainn and Ionad Eibhlis. As found on the previous inspection these names were not in use by staff and staff were heard referring to them as module 1 and module 2.

On arrival to the centre inspectors met with the person in charge. Inspectors noted that although there was a visitors sign in book inside the front door, there was no person assigned to the reception desk to monitor people accessing the centre. Inspectors saw a number of members of the public accessing the public health services which were accessed from a door in the middle of the registered centre. They did not sign in and could access the centre freely. Following a discussion with the person in charge to outline the purpose of the inspection the inspectors commenced a walk around of the centre. Inspectors saw that the general manager for older persons and the person in charge were meeting with a group of staff in the main sitting room. Inspectors were informed that this was taking place to discuss and explain the current quality improvement plan and changes being implemented in the centre in response to the poor findings of the previous inspection.

Inspectors spent time walking around Ionad Bhreannainn and Ionad Eibhlis and visited the communal rooms in the centre. On the first afternoon of the inspection inspectors saw that there was a lively music session with approximately ten residents in one of the communal rooms and following this the musician visited residents in their rooms and sang songs with them. Inspectors were informed that

this had been introduced as a weekly activity every Wednesday since the previous inspection. Residents told the inspectors that they really enjoyed the live music and interaction. Inspectors enquired as to the lunchtime meal as there were no residents or staff in the dining room. Staff told inspectors that lunch was served at 12 midday for all residents. There was no evidence in a review of residents' meetings or surveys that residents had been consulted with regarding this time. Inspectors observed that some residents were brought to the dining room at 11:50am for their dinner. This finding did not respect residents' choice and is further detailed under Regulation 9; Residents Rights.

Residents were seen to be using the communal spaces within the two units, watching quiz shows and conversing with staff and inspectors saw that staff encouraged a number of residents to come out of their bedrooms. However, the inspectors did observe that there continued to be a large number of residents who remained in their bedrooms throughout the day. Staff spoken with told inspectors they loved working in the centre and they had received training since the previous inspection on person centred care and residents rights which they found beneficial. Inspectors also saw that a practice development coordinator from the HSE was working with staff and discussing the importance of a social model of care delivery.

Inspectors observed that some residents' bedrooms were personalised with pictures of their families and soft furnishings. Since the previous inspection shelving was being hung in some bedrooms to facilitate and encourage residents to bring in their personal belongings. Bedroom accommodation in the centre was predominately shared. Over 60 percent of residents lived in twin or four bedded rooms. Inspectors were informed that 11 of the 43 beds in the centre were allocated for short stay residents, such as community support, convalesce and respite care. However, inspectors noted that it was the custom and practice of management in the centre to move residents from their bedrooms to facilitate new admissions to the centre. Inspectors also found that short stay residents were accommodated in single bedrooms, whereas residents living in the centre full time were living in the multi-occupancy rooms. This practice did not reflect understanding that the centre is "home" to long term care residents or respect residents' rights and is further detailed under Regulation 9. Inspectors also observed on the walk around of the centre that some residents had full bedrails in place and they were not allocated bedrails as per the restraint records. This was also a finding on the previous inspection and is actioned under Regulation 16 and 7.

Communal space for residents in the centre was mainly located off the large open foyer area, past the reception. This included the main sitting/day room in the centre called Croi (Heart), a dining room and a visitor's room. The inspectors saw that there was more use of these areas since the previous inspection and plans were being put in place to change access for people using the public health services, which had its entrance in the middle of the designated centre. It was also evident that the visitor's room on Ionad Eibhlis was now available for residents use as this had been found to be used for storage of equipment on the previous inspection. Notwithstanding these findings, inspectors saw that after 6pm on the first evening of this inspection the majority of residents were back in their bedrooms and there was

limited use of communal rooms. This is actioned under Regulation 9; Residents Rights.

The inspectors spent time observing the dining experience at lunchtime on day two of this inspection. Since the previous inspection it was evident that improvements had been made with regards to the access to the main dining facilities for residents and furniture had been reconfigured to allow the room to accommodate more residents. Historic practices of residents eating their meals on the tables off the corridor had ceased. Approximately seventeen residents were observed to attend the dining room, and staff were observed to encourage and support residents to enjoy a more sociable dining experience and eat outside of their bedroom environment. Menus had also been updated with the name of the dining room, Café Tintean and these menus were available throughout the centre. Inspectors saw that there were adequate numbers of staff available to support residents during mealtime and assistance during mealtimes was seen to be provided in a respectful and dignified manner. Staff were observed sitting with residents and chatting to them about local news and their families. However, as found on the previous inspection not all residents were afforded a dining experience as the room could not accommodate all 46 residents.

The inspectors spent time observing resident and staff engagement and found that staff interactions with residents were seen to be appropriate and respectful. Residents looked well-groomed and content. Some staff were observed taking residents for walks and conversing with them in Irish. Residents who chose to remain in their bedroom were checked on frequently by staff.

Inspectors noted on the walk around Ionad Eibhlis on the second day of the inspection that the clinical room was left open, which meant that medicinal products and sharps containers were accessible to residents, visitors and unauthorised staff. This room also housed the controlled medications and inspectors saw that the key for these high-risk medications was maintained beside the cabinet in which they were stored which is contrary to medication policies and best practice. Given the risks to resident safety, these matters were brought to the attention of the person in charge and the keys were removed. Later in the day inspectors noted the door continued not to be closed correctly and there was not appropriate supervision to ensure that this risk was mitigated. This finding is detailed under Regulation 29 and 16.

Residents had access to a timetable of activities, and the activities programme had been reviewed and enhanced since the previous inspection, with commitments given to increase resources in this area. The person assigned to activities had commenced training in the SONAS programme, to facilitate sensory therapeutic activities for residents living with dementia. Over the course of the inspection, residents were observed attending a group music session, a Zumba class and arts & crafts and a quiz. Despite these improvements, further action was required to ensure activities were planned for the evening time and they were meaningful for all residents, in particular for residents who could not partake in group activities.

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 the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced risk inspection to monitor the centre's compliance with the care and welfare regulations and to follow up on the previous inspection of the centre of March 2026, which found a lack of comprehensive management systems and poor regulatory compliance in eight regulations. Following the previous inspection the provider was requested to attend a warning meeting and a Notice of Proposed Decision (NOPD) to attach a condition to the centre's registration, to cease admissions, was issued. The provider made representation to this legal notice outlining the actions they intended to take to address the significant areas of non-compliance. As part of this inspection, inspectors reviewed the representation submitted by the provider. Findings of this inspection were that although the provider had taken some steps to address poor findings of the previous inspection, significant action was required as non-compliance persisted in the areas of residents' rights, training and staff development, staffing, the supervision of care delivery, notification of incidents, medication management, governance and management and the use of restraint. These findings will be detailed under the relevant regulations of 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 Older Person Services and a General Manager for Older Persons, as well as a person in charge. The person in charge reports to a General Manager in the HSE, who was present on both days of this inspection and who inspectors were informed, was available for consultation and support daily. The service is also supported by centralised departments, such as human resources, fire and estates and practice development.

The provider had been granted a certificate of renewal of registration of the centre, effective from October 2025. As part of this process the Chief Inspector assesses the governance and management arrangements of the registered provider. Although it was evident that there was a defined management structure in place and the lines of authority and accountability were outlined in the centre's statement of purpose, the senior managers with responsibility for the centre were not named as persons participating in management (PPIM) on the centre's registration. The provider was required to review these arrangements and was afforded until November 28th, 2025, to do so. On the day of this inspection, the HSE remained in breach of this condition of their registration. Although the provider had recently notified the Chief inspector of the appointment of a PPIM, the HSE had yet to submit all required

documentation. In the absence of this documentation, it was not possible to complete the processing of the notification or to remove this condition.

As part of the provider's commitment to improving the governance of the centre, the provider had formulated a West Kerry Regional support team which met weekly to discuss all areas of governance. Members of this team included senior management, the person in charge, HSE safeguarding staff, a geriatrician, members of the quality and patient safety team, practice development and human resources. Inspectors saw that new systems of monitoring incidents, audits and training were being planned and developed. However, these systems were at a very early stage and were not yet fully implemented into the management systems. As found on the previous inspection the governance and management systems in place were not effective, to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored.

Within the centre care is directed by the person in charge who is supported by a clinical nurse manager and a team of nursing, health care, household, catering, activity and maintenance staff. Following the findings of the previous inspection the registered provider had committed to recruiting two additional clinical nurse managers, additional activities staff and healthcare assistants. At the time of the inspection these posts were currently being progressed through the human resource department. From an examination of the staff duty rota and communication with residents and staff it was found that the levels and skill mix of staff at the time of inspection were sufficient to meet the needs of residents during the day. There were three registered nurses and three healthcare assistants on both Ionad Bhreannainn and Ionad Eibhlis. The provider had committed to increasing staffing resources in the evening and at night to address the findings of the previous inspection in relation to the allocation of resources at this time. However, this had not been actioned as committed to which had an impact on residents' rights.

From a review of training records, and from speaking with staff, it was evident to inspectors that staff working in the centre had received additional training in person centred care, residents' rights and the use of restraint, in response to the findings of the previous inspection. Inspectors were informed that training in gerontology was booked to take place in the weeks following the inspection, being facilitated by a consultant geriatrician. Notwithstanding that staff had received additional training in these areas, further action was required to ensure they were effectively supervised and that they implemented the principles of training into practice, particularly in relation to residents' rights and the use of restraint. Inspectors also found that there was not an adequate system in place to monitor staff attendance at training. These findings are further detailed under Regulation 16; Training and Staff Development.

Some improvements were noted in the management of complaints. The registered provider had ensured that the nominated complaints officer had received suitable training since the previous inspection to deal with complaints, and the policy had been updated. However, from discussions with staff and management it was evident that there were two methods of recording complaints and inspectors were not satisfied that complaints were managed within the timelines set out in the

regulations. These findings are detailed under Regulation 34; Complaints Management.

Records requested over the two days were provided to the inspectors. It was evident that all Registered Nurses had submitted their NMBI registration details to the person in charge, which evidenced that they were named on the live register of nurses in Ireland. A sample of contracts of care were reviewed and it was found that not all were accurate with regards to the room the resident resided in and the number of residents living in the room. Although incident records reviewed were seen to include more detailed information in relation to events surrounding the incident and the actions taken, which was a noted improvement since the previous inspection, one notification had not been submitted to the Chief inspector, as required by the Regulations.

Regulation 15: Staffing

As found on the previous inspection the levels and skill mix of staff after 8pm was insufficient to meet the needs of residents. There was one RGN and one HCA allocated to work from 8pm to 8am on Ionad Bhreannainn and Ionad Eibhlis. However, these staffing arrangements did not facilitate or support residents to use the communal rooms, outside of where their bedrooms were located. The provider had submitted their representation dated 13th April 2026 that a business case had been approved to increase staff working on night duty to facilitate residents choice and access to communal areas. However, this had not been progressed at the time of this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

As found on the previous inspection significant action was required pertaining to the supervision of staff and the provision of training. For example:

- The registered provider had failed to ensure that effective measures were in place for the supervision of staff to ensure they implemented the local policies in practice. For example, inspectors found poor adherence to the use of restraint, residents rights, and medication management practices. Inspectors observed institutionalised practices in the centre continued to be embedded into culture of the centre.
- There was a lack of oversight of staff training as the system in place to monitor staff training was not effective as the record was not completed. Therefore, it was not possible to determine who was due mandatory training.

Judgment: Not compliant

Regulation 21: Records

The provider had addressed the findings of the previous inspection with regards to maintaining complete incident records and ensuring a directory of all visitors to the centre was maintained. Inspectors were assured that the provider maintained a record of all registered nurses' current registration details which as per the centres policy they were required to submit yearly. As referenced under Regulation 16, the records pertaining to staff training were incomplete.

Judgment: Compliant

Regulation 23: Governance and management

As found on the previous inspection the overall governance and management of the centre was not fully effective. Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example:

- The audit system was not effective in identifying areas for improvement as identified on this inspection. The service had not developed and implemented a system to record key clinical performance indicators, such as the use of restraint, dependency levels of residents, the number of wounds, and infections. This is required to ensure there is effective oversight of clinical care.
- The management systems and oversight arrangements in place to provide assurance regarding the secure storage of medicinal products were ineffective; for example, inspectors found medications accessible and not secured in one of the clinical rooms. The management team was requested to address the storage of medicinal products immediately.
- The oversight of incident reporting required improvement as a statutory notification to the Chief Inspector in relation to a serious incident which required hospital admission was not submitted within the required time frames. This was also a finding on the previous inspection.
- The registered provider had failed to implement some of the actions set out in their representation submitted to the Chief Inspector, such as the effective monitoring of the use of restraint within the centre, reducing institutionalised practices as well as an increase of staff allocation at night.
- The provider failed to ensure that residents rights were protected within the centre evidenced by the practice of relocation long term care residents from their single bedroom into four bedded rooms, the lack of provision of a dining experience for all residents and lack of social stimulation.

- There was not a system in place to monitor people entering the designated centre particularly members of the public attending for outpatient appointments. This posed a risk to residents.

The registered provider had not complied with the restrictive condition placed on the centre's registration. This condition stated that: "The registered provider shall, by the 28th November 2025, submit to the Chief Inspector the information and documentation set out in Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 as amended, in relation to any person who participates or will participate in the management of the designated centre.' While the registered provider submitted the required notification to the office of the Chief Inspector, in the weeks preceding the inspection, regarding the notification of a person participating in the management of the centre, documentation required to progress the notification was still outstanding, therefore the HSE remained in breach of this condition of their registration.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

A sample of contracts for the provision of care were reviewed and found that the terms relating to the admission of a resident to the centre, including terms relating to the bedroom to be provided and the number of occupants of that bedroom were not clearly described, as required by Regulation 24(b).

Judgment: Substantially compliant

Regulation 31: Notification of incidents

One incident had not been reported to the Chief Inspector, as required under the regulations, within the required time period. This related to a serious incident to a resident that requires hospital admission.

Judgment: Not compliant

Regulation 34: Complaints procedure

Complaints management required action as evidenced by the following findings:

- Although, there was a clearly outlined complaints procedure in place and there was a complaints log on each unit, four nursing staff spoken to were

unsure how to log a complaint. They informed inspectors that they had never taken and logged a complaint from a resident or relative, despite perhaps being the senior member of staff in the centre at weekends or evenings. When requested, they were unable to locate the complaints book so the inspectors were not assured that the complaints policy was being adhered to.

- The inspectors did see a complaints log, however, it was noted with regards to a number of complaints, there was no follow up to the complaints documented.
- One complaint reviewed demonstrated a protracted completion time, significantly exceeding the timelines outlined in the centre's policy.

Judgment: Substantially compliant

Quality and safety

Although residents in the centre were generally satisfied with the quality of the service, they received this inspection found that significant action was required in relation to residents' rights, medication management, care planning, and the use of restraint, which will be further detailed under the relevant regulations. As found on the previous inspection of the centre the quality and safety of care provided to residents was compromised, as a result of ineffective systems of governance and management.

Care planning documentation was available for each resident in the centre, as per regulatory requirements. A pre-admission assessment was completed to ensure the centre could meet the residents' needs. Some care plans reviewed were person centred and were sufficiently detailed to direct care. However, improvements were required in care planning as some information with regards to residents' clinical care was not clearly documented in their care plan, which is further detailed under Regulation 5 of this report.

Residents had good access to a General Practitioner (GP) who visited the centre regularly. There were established pathways for referral to a team of health and social care professionals for additional expertise and review. This included mental health services, geriatrician services and dietetics. A review of residents' records found that treatment plans by GP's and health and social care professionals were incorporated into residents' care plans. Following the findings of the previous inspection wound care assessments had been reviewed and enhanced.

Residents had access to pharmacy services. Medication administration charts were maintained in line with professional guidelines. However, as mentioned earlier in the report, inspectors found that the storage of medication including controlled medications was not in line with the providers policy or best practice and this posed

a risk to the delivery of a safe service. This finding is actioned under Regulation 29: Medication Management.

Residents had access to national and Kerry newspapers, the Internet, televisions, and radios. They also had access to independent advocacy services, and records reviewed found that several residents had been referred for advocacy support. Although some actions had been taken to address residents' rights and institutionalised practices found on the previous inspection, further actions were required by the provider to promote a culture where a human rights-based approach to care was central to how residents were supported in the centre. Findings in relation to residents' rights are detailed under Regulation 9.

Regulation 29: Medicines and pharmaceutical services

Practices observed in relation to the storage and of medications were not in line with best-practice medicines guidance. For example:

- Medications which require strict controls, were stored inappropriately. Although they were found to be stored in a locked cupboard the keys to this cupboard were left in the clinical room in an unlocked cabinet. The room was also found to be unlocked on several occasions throughout the inspection. Keys to controlled drug cupboards must be strictly managed and kept under the control of a nurse at all times, in line with medication best practice. Therefore this practice may result in uncontrolled access to these medications.
- Inspectors observed that a clinical room was routinely left unlocked by staff on Ionad Eibhlis. This room was used to store medications, nutritional supplements and sharps containers (bins for needles) as well as the controlled medications. This posed a risk to residents accessing these products or unauthorised public access.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example:

- A resident who had been residing in the centre for over two months did not have sufficient detail in their care plan to direct their care delivery in relation to the use of restraint, continence care and their high falls risk.
- Residents end of life care wishes and advanced care directives were not always recorded in their care plan.

- There was not always evidence of a comprehensive assessment every four months, as per the requirements of the regulations to determine if residents needs and support requirements had changed.

Judgment: Substantially compliant

Regulation 6: Health care

In response to the findings of the previous inspection the registered provider had arranged for a consultant geriatrician, who specialises in the health and medical care of older people to visit the centre and they were actively involved in the provision of training for staff in gerontology and care of the older adult. The health of residents was promoted through ongoing medical review and access to a range of external community and outpatient-based healthcare providers such as chiropodists, dietitians, physiotherapy, occupational therapy, speech and language therapy and palliative care services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

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

- It was difficult to determine the number of staff who had training in the management of responsive behaviors, as training records were not available for review.
- The number of residents observed to have bedrails in use did not correlate with the register maintained in the centre.
- Residents needs in relation to behavioural and psychological symptoms and signs of dementia were not always documented in their resident's care plan to ensure that supports were put in place to address identified needs.

Judgment: Not compliant

Regulation 8: Protection

Following the findings of the previous inspection the registered provider had taken action to safeguard residents. Inspectors found that where safeguarding investigations were required these had been progressed as per the centres policy.

There had been consultation with the HSE safeguarding team to guide and support the management team in safeguarding systems.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure residents rights were upheld in the centre and residents choice was respected. This was evidenced by the following findings:

- As found on previous inspections institutional practices were observed which did not respect or promote residents' rights. For example; the staff practices of moving a resident from their single bedrooms into a four bedded room. This did not respect residents' rights.
- Although the activities programme had been reviewed and enhanced since the previous inspection it remained limited, particularly in the evening. The inspectors observed that residents spent the evening in their bedrooms with minimal stimulating activity.
- The times that the lunch time meal were served was found to be very early and there was no evidence that residents were consulted with in relation to this. As found on the previous inspection some residents also did not have access to a dining experience as the dining room could not accommodate all residents living in the centre and there continued to be only one sitting.

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	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ospideal Pobal Chorca Dhuibhne (West Kerry Community Hospital) OSV-0000569

Inspection ID: MON-0050531

Date of inspection: 14/05/2026

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
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Person in Charge has completed a review of the staffing levels and skill mix in place after 8pm within Ionad Bhreannainn and Ionad Eibhlis. Following this review, an increase of 2.58 WTE Health Care Assistants (HCA) on night duty has been approved and progressing. This enhancement is specifically intended to support residents to access communal areas outside of their bedrooms during evening hours, thereby promoting resident choice and a social model of care delivery. These measures ensure that appropriate staffing levels are in place after 8pm to safely and effectively meet residents' assessed needs. These actions demonstrate the provider's commitment to maintaining safe staffing levels, supporting person-centred care, and ensuring effective governance and oversight within the designated centre.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Registered Provider has implemented the following actions within the designated centre to strengthen governance, safeguarding, supervision, and the delivery of person centred care: Management and Supervision • Recruitment of Clinical Nurse Manager II (CNM II) posts is underway to strengthen clinical oversight and supervision, interviews are scheduled for the 22nd /23rd July 2026. • Nursing management or nominated deputies are providing daily oversight and supervision to ensure staff implement the local policies in practice. • An enhanced training matrix is currently in place to monitor staff training.	

- The new enhanced training matrix provides a clear and auditable overview of all trainings to be completed by all team members. The completion dates trigger an inbuilt alert system to indicate in a timely manner when each team members training is next due for renewal.
 - A training needs analysis is in progress to identify gaps and inform training delivery.
 - Management walk-throughs are in place to monitor care practices, address institutionalised behaviours, and provide on-the-spot coaching. Person-Centred Care and Residents' Rights
 - Nursing management provides daily supervision at ward level to ensure a person-centred approach to care delivery is being embedded. This practice is supported by targeted staff training.
 - Nursing management provides daily supervision at ward level to ensure the robust assessment, consent, and communication processes for restrictive practices are implemented and adhered to. All bedrails are recorded on the ward restraint register. The restraint register is reviewed and signed daily by nursing management.
 - Nursing management have liaised with all nursing team members on the appropriate storage of medicinal products and ensuring practice is aligned to local policy and best practice guidelines.
 - Daily supervision by nursing management is ongoing to ensure adherence is embedded.
- Education and Training
- A structured training programme has been completed. The structured trainings scheduled include safeguarding, human rights-based care, person-centred care, advocacy, and restrictive practice.
 - CNM II undertaking delegated safeguarding officer training (week commencing 13th July)
 - A bespoke training matrix is in place to ensure training compliance is monitored and auditable. The training matrix clearly distinguishes mandatory training from essential training to support audit across all disciplines. The completion dates trigger an inbuilt alert system to indicate in a timely manner when each team members training is next due for renewal. These actions support improved governance, staff competence, and the delivery of safe, rights-based, person-centred care.

Regulation 23: Governance and management

Not Compliant

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

- The Person in Charge has implemented a new system to track weekly key clinical performance indicators, such as the use of restraint, dependency levels of residents, the number of wounds, and infections to ensure effective oversight of clinical care.
- The Person in Charge immediately addressed the storage of medicinal products to ensure effective secure storage. The Person in Charge liaised with all nursing team

members on the appropriate storage of medicinal products and medications which require strict controls. The keys to the locked controlled drug cupboards are now always held by a nurse on duty, in line with medication best practice. Nursing management are completing daily surveillance to ensure adherence is embedded at ward level.

- Daily supervision by nursing management is ongoing to ensure adherence is embedded in practice.

- The Person in Charge has submitted the statutory notification to the Chief Inspector. A Statutory Notifications Reference Folder has been developed and implemented within the designated centre. This resource provides nursing management with clear guidance on; statutory notifications required under Schedule 4, associated submission timeframes, and the roles and responsibilities for notification management.

- The Registered Provider reviewed the actions set out in the previous compliance plan submitted to the Chief Inspector in relation to; effective monitoring of the use of restraint within the centre, reducing institutional practices and increase of staff allocation at night. Bedrail documentation education has been delivered to all nursing staff. Nursing management provides daily supervision at ward level to ensure robust assessment, consent, and communication processes for restrictive practices are implemented and adhered to. All bedrails are recorded on the ward restraint register and updated daily. The restraint register is reviewed and signed daily by nursing management. Current evening routines are under review to ensure residents are supported to exercise choice regarding their bedtime. The service is working to eliminate institutional practices and promote a person-centered approach whereby residents' preferences, rights and quality of life are prioritised. This approach is facilitated as much as possible while awaiting the approved uplift in staffing.

Regulation 24: Contract for the provision of services	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

The Person in Charge is co-ordinating a whole centre review of the contracts for the provision of care to ensure that the terms relating to the admission of a residents to the centre, including terms relating to the bedroom to be provided and the number of occupants of that bedroom are clearly described. The review will be completed by 17/07/2026

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Statutory Notifications, Oversight and Support Arrangements

The statutory notification has been submitted to the Chief Inspector in accordance with the requirements of Schedule 4 of the Health Act 2007.

A Statutory Notifications Reference Folder has been developed and implemented within the designated centre. This resource provides nursing management with clear guidance on:

- The statutory notifications required under Schedule 4,
- Associated submission timeframes, and
- Roles and responsibilities for notification management.

This system supports compliance and ensures consistent awareness and oversight of notification requirements.

Education sessions have been delivered to WKCH management on the identification, management, and timely submission of statutory notifications. A mentorship arrangement has been established to support the Director of Nursing. This mentorship provides structured professional support, guidance, and governance oversight, particularly in relation to regulatory compliance and management responsibilities.

Regulation 34: Complaints procedure	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The Registered Provider has strengthened complaints management through the following actions:

- A standardised complaints recording process has been implemented across Ionadh Bhreannainn and Ionad Eibhlis, with all complaints submitted to the Director of Nursing (DON) for review and action.
- A centralised complaints log is maintained within the centre to support oversight, governance, and trend analysis.
- All complaints and feedback are escalated to and reviewed by the Person in Charge to ensure timely and appropriate responses.
- Staff awareness has been reinforced to ensure all expressions of dissatisfaction are recognised, recorded, and managed in line with policy.
- Centre-specific details of the Complaints Officer and Review Officer are incorporated into the complaints policy to ensure clarity and accessibility.
- The Person in Charge has received additional support from the Regional Service Feedback Manager to ensure consistency with policy and regulatory requirements.
- The nominated Complaints Officer has completed appropriate training to support effective complaints management.
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These actions support a transparent, accessible, and effectively governed complaints process.

Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • The Person in Charge immediately addressed the storage of medicinal products to ensure effective secure storage. The Person in Charge liaised with all nursing team members on the appropriate storage of medicinal products and medications which require strict controls. The keys to the locked controlled drug cupboards are now always held by a nurse on duty, in line with medication best practice. Nursing management are completing daily surveillance to ensure adherence is embedded at ward level. • The delayed locking mechanism of the clinical room door in Ionad Eibhlis has been notified to the maintenance department. In the interim, all nursing team members are aware to ensure the door is locked on exiting the clinical room. Daily supervision by nursing management is ongoing to ensure adherence is embedded in practice.	
Regulation 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: The Person in Charge is coordinating a review of all individual assessments and care plans to ensure the needs of each resident has been assessed and an appropriate care plan prepared to meet these needs. • The care plan of the identified residents has been reviewed and updated to ensure their care plan directs their care delivery in relation to the use of restraint, continence and their high number of falls risk factors. • All resident care plans have been reviewed to ensure end of life care wishes and advanced care directives are recorded in accordance with the residents wishes. • All resident care plans have been reviewed to ensure a comprehensive assessment has been undertaken to determine if residents' needs and support requirements have changed. A new oversight and management system has been implemented to ensure all formal evaluations and reviews are completed within the specified 'at intervals not exceeding 4 months' timeline as per the requirements of the regulations.	

Regulation 7: Managing behaviour that is challenging	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: The Registered Provider will implement the following actions to achieve compliance: • A bespoke training matrix is in place to ensure training compliance is monitored and auditable. All staff have now received training in the management of responsive behaviour. • The Person in Charge is coordinating a review of all resident care plans to ensure residents needs in relation to behavioural and psychological symptoms and signs of dementia are documented to ensure all necessary supports are in place to address identified needs. • Bedrail documentation education has been delivered to all nursing staff. Nursing management provides daily supervision at ward level to ensure the robust assessment, consent, and communication processes for restrictive practices are implemented and adhered to. All bedrails are recorded on the ward restraint register and updated daily. The restraint register is reviewed and signed daily by nursing management. These actions support safe, consistent, and least restrictive management of responsive behaviours within the designated centre.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The registered provider has acknowledged the residents' rights to privacy and dignity, and respects their chosen room to reside in which honours their human rights and autonomy. Residents will not be moved without their engagement and consent. A comprehensive activities programme is continuously being enhanced with recommendations being sought from the residents in relation to preferences, likes and dislikes. Approval has been granted to support the provision of activities by introducing a 1.83 WTE activities co-ordinator to provide 7-day cover across the service. Engagement with the residents through a survey has denoted that a preference for a later lunch time would be welcomed. Senior management is currently undertaking negotiations with the catering department to deliver this request.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	01/07/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the	Not Compliant	Orange	30/08/2026

	effective delivery of care in accordance with the statement of purpose.			
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	06/07/2026
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	01/08/2026
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that	Substantially Compliant	Yellow	17/07/2026

	resident shall reside in that centre.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	01/07/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	01/07/2026
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	01/07/2026
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	Substantially Compliant	Yellow	07/08/2026

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	24/08/2026
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	01/07/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	01/07/2026
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	01/07/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably	Not Compliant	Orange	01/07/2026

	practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
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