



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:	16 June 2025
Centre ID:	OSV-0000569
Fieldwork ID:	MON-0038201

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:	41
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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
Monday 16 June 2025	13:15hrs to 19:00hrs	Breeda Desmond	Lead
Tuesday 17 June 2025	08:30hrs to 16:00hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over two days in Ospidéal Pobal Chorca Dhuibhne (West Kerry Community Hospital (WKCH)). The inspector met with many residents during the inspection, and spoke with two visitors. The inspector spoke with nine residents in more detail to gain insight into their experience of living there. Residents gave positive feedback about the centre and were complimentary about the staff and the care provided, and said that the food was excellent and looked forward to their meals. They reported that art classes had started and they really enjoyed them; they said they had never painted before but realised they had a flare for it; they were looking forward to the end of the week to finish off their art projects.

On arrival for this unannounced inspection, the inspector completed the centre's risk management procedures which included a signing-in process and hand hygiene. The centre was a large single-storey building that also accommodated the mental health day service and community public health. Orientation signage was displayed to guide residents and visitors to the two units of Ionad Bhreannan and Ionad Eibhlis to allay confusion and disorientation. The main entrance was wheelchair accessible. The central space beyond main reception had comfortable seating areas to relax. These seating areas were upgraded since the previous inspection with additional armchairs and two aquaria which residents said they loved.

An Croí (The Heart) was a large room on the left and was used for larger groups activities such as bingo, arts and crafts and music events. The main kitchen, laundry and other offices were located beyond An Croí. The oratory was located on the right corridor leading to the two units. This was a beautiful room with hand-crafted wood altar and tabernacle; the priest was on site every Wednesday to say mass for residents. A new electric candle stack was presented to the centre by the 'Friends' of WKCH and residents said they were delighted to be able to light a candle, like they used to, for their family and friends. The fire door to this room was repeatedly maintained open with a door wedge even though it was highlighted on inspection that the use of door wedges is contra-indicated for fire doors.

The main dining room was immediately in front of An Croí; this room was upgraded since the last inspection; it was beautifully decorated and set out restaurant-style and could accommodate approximately 15 residents for their meal. The 'Friends of WKCH' donated a coffee machine to enable residents and visitors to make coffee; this was installed in the main dining room and the inspector observed families making coffee, sitting and chatting with their relative in the dining room.

On the daily duty roster displayed by the nurses' station, staff were assigned to different roles such as the nurse on duty and health care assistants (HCAs') for example; however, there was no one assigned to activities on the roster to ensure residents had access to meaningful activation. On the second day of inspection, the duty roster had a member of staff assigned to activities and the inspector saw seven

residents in the day room enjoying chair exercises facilitated by a HCA; following this, bingo was scheduled in An Croí. The inspector spoke with several residents after bingo and they said they really enjoyed it, 'it's great fun' and showed their winnings.

One enclosed garden had an array of freshly planted flowers in the raised beds and flower pots donated by the 'Friends of WKCH'. It was a gorgeous day with temperatures of 22 degrees, and throughout the afternoon and evening there was no one in either garden.

A weekly calendar was displayed on each unit showing the daily activities. The activities programme indicated that tea/coffee from 10:30am – 11:15am was a social occasion to meet-up with friends and chat, however, there was just one resident in the day room on one unit at 10:30am, and routinely, beverages were served to residents in their bedrooms. During the morning, afternoon and evening, the inspector saw that many residents remained in their bedrooms, with a maximum of seven residents in the day room at any time.

Lovely interaction was observed between a nurse and a resident whereby the nurse encouraged the resident to play the piano; she sat and chatted while the resident played several pieces. The resident was delighted with the company and following the recital, the nurse offered her a cup of tea. There were two other residents chatting in the dining area and one resident meandering the corridors, the remainder of the residents were either in bed or in their bedrooms at 6pm.

Both Ionad Bhreannan and Eibhlís were secure but had butterfly images with the key-code displayed to enable independent access. Residents were seen using this code to independently exit and enter their units. Both units were similarly set out and were self-contained regarding facilities which included the nurses' station, clinical rooms, sluice rooms, dining areas and day rooms. Both had access to enclosed outdoor gardens; one garden was well maintained and had beautiful murals of scenes of local places painted, raised flower beds and garden furniture seating; the second garden was not as well maintained.

Residents accommodation was set out as follows: Ionad Bhréannainn, a 22 bedded unit and Ionad Eibhlís, a 24 bedded unit, both with single, twin and four bedded multi-occupancy rooms. New double wardrobes were installed, so now all residents had a double wardrobe to store their clothing. New colour schemes with duvets covers, bedroom curtains and art work were provided by the 'Friends of WKCH'. Some single bedrooms were personalised in accordance with residents' wishes and preferences; most twin and multi-occupancy four-bedded rooms were clinical and did not reflect a homely residential care setting.

Overall, the premises was bright and easily accessible and the atmosphere was calm and relaxed. Staff were seen to actively engage with residents when providing assistance. Some residents were seen to mobilised independently around the centre including out to the main entrance to one of the seating areas by the aquarium. The physiotherapist was on site during the inspection providing individualised care to residents, mobilising them in accordance with their assessed needs and providing

support and guidance to enable better outcomes for them. One resident required an x ray and a mobile x ray was facilitated which negated the resident having to go to the acute care setting for this investigation.

There were two small dining areas on both units; these comprised two tables in open spaces which led to the outdoor gardens. One of the staff painted a large beautiful mural on the wall of one dining area to enhance the setting; however, in general, these spaces were not suggestive of dining rooms or set out or furnished to enhance a dining experience for residents. In all, the inspector saw six residents in one unit and four in the second unit having their main meal in the dining area, 15 residents had their main meal in the main dining room and the remainder (17) had their meal in their bedrooms. Residents had menu choice regarding their meals, and complimented the quality of food served. Medications were administered after the main meal to ensure residents could enjoy their meal undisturbed.

The inspector observed that the door to the clinical room was unsecured which enabled unauthorised access. Despite the inspector locking it several times, the lock was activated to prevent the door closing securely. This clinical room had medications, clinical equipment and clinical sharps bins with disposed needles.

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 provided.

Capacity and capability

This was an unannounced inspection conducted by an inspector of social services to inform the application to renew registration of Ospideal Pobal Chorca Dhuibhne (West Kerry Community Hospital), and to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations.

While some improvement was noted, the findings of this inspection were similar to the last inspection in that dining experience for residents required improvement, access to meaningful activation was limited and institutional practices remained evident. Improvement was noted regarding aspects of residents records, medication management, aspects of fire safety precautions and the premises. On this inspection, action was required to comply with the regulations in relation to Schedule 5 policies and procedures, food and nutrition, care planning, and institutional practices relating to residents' rights. These will be further discussed under the relevant regulations in this report.

Ospidéal Pobal Chorca Dhuibhne (West Kerry Community Hospital) is a residential care setting operated by the Health Services Executive (HSE). It is a 54 bedded centre, registered to accommodate 46, however, due to staffing levels, it is currently

accepting 42 residents. The registered provider applied to register 46 beds as part of this application.

As part of ongoing monitoring of designated centres, 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 with lines of authority and accountability, the senior managers with responsibility for the service were not named as persons participating in management as part of the application to renew registration.

The governance structure comprises a newly appointed general manager for the CH04 area of the HSE, who is the person appointed to represent the registered provider. The person in charge reports into the general manager. Off site, the service is supported by the clinical development co-ordinator, clinical operations manager, quality and safety adviser, infection control link nurse specialist and human resources. On site, the person in charge is supported by the clinical nurse manager (CNM) who deputises on occasions when the person in charge is absent. A comparison of staffing from the previous renewal of registration showed deficits in the resources available to the service which included a CNM, catering manager, and two healthcare assistants.

Policies and procedures relating to Schedule 5 were viewed and areas for improvement are further detailed under Regulation 4: Written policies and procedures. Notifications in accordance with regulatory requirements were timely submitted. A review of the incident and accident records showed that notifications correlated with these. Improvement was noted in the management of complaints and comprehensive records of these were maintained. The training matrix indicated that mandatory and other training was facilitated for staff, appropriate to their various roles.

The person in charge discussed the quality improvement initiatives following the findings of the last inspection. The main dining room was now operational and looked really well, albeit, it could only accommodate 15 residents at a time.

Staffing duty rosters were examined and a review of twilight hours staffing was requested; the rationale for this is further discussed under Regulation 9: Residents' rights.

Registration Regulation 4: Application for registration or renewal of registration

The provider had applied to renew the registration of the centre for 46 beds. The appropriate fees were paid, the application form was submitted with the required information set out. Floor plans and statement of purpose were updated following the inspection to reflect the centre and service provided.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge met the requirements of the regulations; she was full-time in post and was involved in the governance, operational management and administration of the designated centre. Observation showed that she was familiar with residents and their care needs.

Judgment: Compliant

Regulation 15: Staffing

A review of the staffing roster regarding twilight hours was requested as there was one nurse and one HCA on night duty from 8pm to 8am on each unit. Due to their assessed needs, many residents required two staff to provide personal care and comfort rounds in addition to the nurse completing medication rounds following change of shift at 8pm, this meant that the HCA was the only staff to answer call bells and provide care. This is further discussed under Regulation 9: Residents' Rights.

Judgment: Compliant

Regulation 16: Training and staff development

Training needs analysis formed part of staff annual performance reviews and additional training was facilitated. Mandatory training was facilitated and further training was scheduled in the weeks following the inspection to ensure staff training remained current. Additional on-site training such as wound care, medication management, palliative care and assessment of capacity was provided.

Judgment: Compliant

Regulation 23: Governance and management

Senior managers with responsibility for the service (as detailed in the statement of purpose) were not named as persons participating in management as part of the application to renew this registration.

Regarding management systems:

- Some were not sufficiently robust to ensure that the service provided was appropriate, consistent, and effectively monitored as:
 - there were limited meaningful activation for residents on a daily basis
 - institutional practices continued to be evident (as detailed under Regulation 9: Residents' rights).

Regarding resources:

- there were deficits in resources available to the service in comparison to the previous statement of purpose the centre was registered against, with a shortfall of a CNM, HCAs x 2 and catering staff.

Regarding risk:

- the clinical room on one unit was routinely left open with the lock activated which enabled unauthorised access; this room had clinical supplies such as medications, equipment and sharps containers. This was a repeat finding.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required updating as follows:

- the name of the centre to reflect the current name
- services provided under the medical card scheme for residents
- organisation structure to reflect the HSE management structure in place
- current conditions under which the centre is registered
- role and responsibilities of the CNM to be reviewed as those detailed reflected the role and responsibilities of the person in charge
- number of staff employed in the centre
- floor plans to reflect the centre and to include measurements of all rooms being registered
- complaints procedure to include how someone can make a complaint.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notification, as specified in the regulations, were timely submitted to the regulator. A review of the incident and accident records demonstrated that notifications correlated with these.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of complaints records showed improvement in records maintained with comprehensive information about the complaint, follow ups and liaising with the complainant to ensure they were satisfied with the outcome of an investigation. The complaints procedure displayed was easily accessible and described simply how to make a complaint and who people could speak with when they had a concern.

Judgment: Compliant

Regulation 4: Written policies and procedures

Some policies were out of date or not available, nonetheless, assurances were provided that these had been updated and were awaiting sign-off. For example, policies relating to admissions, temporary absence and discharge, and management of behaviours that challenge were not in place, and the policy relating to health and safety was out of date.

Judgment: Substantially compliant

Quality and safety

The atmosphere was relaxed and, in general, staff actively engaged with residents in a friendly and respectful manner and visitors to the centre were made feel welcome.

'Friends of West Kerry Community Hospital' were very active supporting the centre. They had provided funding to upgrade many aspects of the premises as described earlier in the report. There were ongoing meetings with the 'Friends' group and management, discussing further quality initiatives that would enhance the quality of life for residents in the centre.

The person in charge facilitated residents to obtain monthly bank statements to enable oversight of their finances. Oversight of residents' health care needs was good. Residents' health care needs were promoted with daily on-site access to the GP, health and social care professionals such as speech and language and dietitian services when required; residents had access to other specialist care such as psychiatry of old age and palliative care for example. The pharmacist attended the centre on a weekly basis and was on site during the inspection.

Observation on inspection showed that staff had good insight into responding to residents' medical and clinical care needs, but not their social care needs. The daily narrative reviewed showed monitoring of care needs as well as monitoring residents' responses to interventions. A sample of care planning documentation was examined and while significant improvement was noted regarding assessments and care planning with medical histories informing both assessment and care planning, these were not updated in accordance with the changing needs of residents. This is further discussed under Regulation 5: Individual assessment and care plan. A daily safety pause was facilitated to remind staff of issues such as residents at risk of falls, skin integrity, absconsion, those on treatments other than routine medications such as eye drops and antibiotics. This was an excellent document that enabled staff to have good oversight of residents and their additional care needs.

While residents gave positive feedback about the quality of food served and were thrilled with the new dining room, there were issues identified relating to the dining experience for residents, and these are further expanded upon under Regulation 18: Food and Nutrition.

As previously described, there was limited social activation for residents. Most staff actively engaged with residents in a social manner, however, a social model of care was not evident as most residents had their meals by their bedsides, and most residents were in their bedrooms by 6:30pm, which is reflective of an acute care model and not a residential social care model of care.

While most multi-occupancy bedrooms had either long-stay or short-stay residents, one bedroom had a mix of short and long stay people which could be disruptive for the long-stay resident with people coming and going from their bedroom continuously; this arrangement would not allow for a long-stay resident to make friends and develop meaningful companionship due to the transient nature of respite and convalescence arrangements.

The residents' forum was facilitated every three months. Minutes of these meetings showed information-sharing such as updates on the refurbishment of the dining room, and feedback from the 'Friends' such as upgrading An Croí to make it more comfortable and welcoming. Outings were organised including trips to the aquarium in town, shopping and coffee, and organising the summer BBQ. Minutes showed that residents really enjoyed the weekly bingo and music sessions. The kitchen staff also attended these meetings when requested to discuss menus, and choices were adjusted accordingly.

Fire safety records showed that appropriate fire certification was in place for alarm tests, emergency lighting and fire safety equipment. Daily fire safety checks were comprehensively completed. Fire safety training was up to date for all staff. Improvement was noted regarding fire safety precautions with monthly drills and evacuations completed; records included response times, staff included in these exercises and hazards identified such as crash mats and low low beds that would impede evacuations. Personal emergency evacuation plans (PEEPs) were available for all residents and these showed residents' evacuation aids for day and night duty. While the PEEPs template had the facility to include a photograph of the resident to enable easy recognition, there were no photographs attached. This and other fire safety issues identified on inspection, are discussed under Regulation 28: Fire precautions.

Regulation 11: Visits

Visitors were welcomed to the centre by staff who were familiar with them. Visitors met with their relatives in day rooms, bedrooms and in the new dining room where a coffee machine was installed and visitors were seen to make coffee to enjoy with their relative.

Judgment: Compliant

Regulation 12: Personal possessions

Improvement was seen regarding personal storage space for residents who now had a double wardrobe to store their clothing as well as a bedside locker. Some had additional chest of drawers, and shelving to display their mementos. Personal laundry was undertaken on site and any issues raised regarding laundry were addressed immediately.

Judgment: Compliant

Regulation 17: Premises

The following were repeat findings and action was required to ensure compliance with Schedule 6 of the regulations:

- the decoration and layout of dining areas on each unit were not suggestive of a dining room as they were located on wide corridor areas with two tables each, which was inadequate to accommodate all residents have their meals in dining areas available to residents

- most communal spaces were not decorated in line with a residential care setting or inviting places to go to socialise; there was limited space in these rooms to accommodate all the residents should they wish to come to the day rooms.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

While residents gave excellent feedback about the choice of menu and the quality of food, action was required to ensure residents were served appropriately:

- tea time was observed on one unit and was seen to require better co-ordination as residents seated together were not served together, some resident were nearly finished their meal before their companion was served, which would not be in keeping with a normal social occasion
- breakfast and supper time was observed on both units and all residents had breakfast either in bed or by their bedside in accordance with staff routines
- due to staff routines, the main dining room was unavailable to residents, so residents did not have choice to use the main dining room for their breakfast or evening meal. [As outlined in Regulation 17: Premises, there were inadequate tables and chairs in the dining areas on each unit, so most residents had no choice but to have their evening meal by their bedside or in bed.]

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

A review of residents records showed that comprehensive information was included in the transfer letter when the resident was admitted to acute care. Residents' notes also showed that the person in charge ensured that comprehensive information was sought upon the residents' transfer back to the centre, to enable the resident to be cared for in accordance with their changed needs.

Judgment: Compliant

Regulation 28: Fire precautions

Action was required to ensure appropriate fire safety precautions as follows:

- the fire folder required updating as a previous CNM/person in charge was detailed as one of the emergency contact numbers
- some fire doors were seen to be held open with door wedges which would impeded the closure mechanism and prevent the fire door closing should the fire alarm be activated; this was a repeat finding,
- some fire doors to communal areas such as the main dining room, hairdressers and oratory for example did not have the free-swing mechanism, and as they were heavy it will be difficult for residents to use these independently, in particular residents using mobility aids such as wheelchairs and rollators; this was a repeat finding
- while the PEEPs template had the facility to include a photograph of the resident to enable easy recognition, there were no photographs attached.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

An antibiotic log, pain assessment and blood sugars records formed part of the medication administration record as part of safe management of residents. Medications requiring crushing were individually prescribed. Controlled drugs were appropriately maintained and records kept in accordance with professional guidelines. Anticipatory palliative care medications were seen to be prescribed as part of residents' care management. Notes in residents' medication management documentation showed comprehensive information from the pharmacist alerting staff to effects of some medications, and maximum dosages regarding 'as required' medications for example.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The following required action regarding residents' assessment and care planning to ensure compliance with regulatory requirements:

- a resident's care plans were not updated following admission to the acute care setting to provide up-to-date information about their changed needs to inform individualised care.

Judgment: Substantially compliant

Regulation 6: Health care

The GP was on site on a daily basis and medications formed part of the review, and residents and staff were consulted with regarding responses to changes in medication to enable best outcomes for residents. Residents had timely access to health care specialist services and timely referrals and consults with allied health professionals such as physiotherapy, speech and language therapist; associated plans of care were in place along with recommendations to support residents to have a better quality of life.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A review of the restrictive practice register was required to ensure all restrictive practices were recorded in accordance with regulatory requirements.

While staff training relating to managing behaviours that challenge was up to date for all staff, one resident's assessment record reported 'getting out of bed' as a responsive behaviour, so staff understanding and knowledge of behaviours that challenge was questionable.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had not ensured the rights of residents were upheld, as:

- while some improvement was noted regarding activities there continued to be limited activities available to residents in accordance with their choice, interests and ability; this was a repeat finding,
- institutional practices were observed with just four residents in communal areas at 5:30pm with the remainder either in bed or in their bedroom on a gorgeous summers evening; this was a repeat finding,
- the activities programme indicated that from 10:30 – 11:15am a 'tea/coffee meet-up' was scheduled, however, on one unit at 11:30am there were two residents in the day room. Teas and coffees were routinely served in residents' bedrooms. Morning coffee was not seen as a social occasion where people met up with their friends to socialise; this was a repeat finding,
- residents in multi-occupancy bedrooms could not independently move or adjust their privacy bed screens due to the mechanism. As these privacy curtains had a minimum of 10 foot brakes to be released to activate them,

residents in wheel chairs or with mobility aids could not use these; this was a repeat finding.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

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

Inspection ID: MON-0038201

Date of inspection: 17/06/2025

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Approval to fill the empty Clinical Nurse Manager 2 post in a permanent capacity has been sought and granted. The recruitment campaign has commenced and suitably qualified candidates will be interviewed in mid-August. Following same it is expected that this post will be permanently filled The deficit in HCAs is being addressed by the recent recruitment process that has identified suitable candidates to fill this documented deficit. There are 2 HCAs and 2 MTAs recruited with one commenced since 24th June 2025 the further 3 posts will be filled by 01st September 2025 The Clinical room which was found open on the day of inspection is locked and access is secure. Managers ensure on daily walk around that access to the room is accessed by relevant staff only	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Statement of Purpose has been updated and re submitted to HIQA shortly after inspection	

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The Policy on the 'Management of Behaviours that Challenge' is now in place and in date within the centre. A process to review and update the 'Admission and Discharge' policy, the 'Temporary Absence Policy' and the 'Health and Safety including Food' policy is being established to ensure the policies are reviewed and updated in accordance with regulatory requirements.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The dining areas which are situated within each module have been decorated and improved since previous inspections. There has been new curtains and pictures added to this area to ensure a more homely setting. A number of old dressers had been refurbished and added to the area and stocked with old tea sets and cookery books. Rising tables to facilitate wheelchair accommodation have been introduced. Tables are set with placemats and tablecloths indicative of a dining area. Residents can also avail of the dining room area off the module for lunchtime meals and looking forward a Quality Improvement Initiative is underway to ensure this area will be available for tea time also While improvements have been made to communal areas with beautiful Muriel's , pictures and soft furnishings in place management will continue to assess and improve – Further planned efforts have been implemented which would enhance the dining space such as diffusers with lemon aroma, salt & pepper mills, stainless steel jugs for water wall planters for flowers have also been sourced. Staff are also considering the practicalities of a decorative privacy screen to set the dining areas apart from the main corridor of the modules. Menus are now also being displayed on each dining table.	

Regulation 18: Food and nutrition	Not Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: Residents sitting together for dining are now being served at the same time allowing residents to enjoy the dining experience as a group if they wish. At all mealtimes residents have a choice of where they will dine – many resident’s choose to stay in their beds or bedrooms at breakfast time ,management and staff will ensure that this is regularly communicated to residents and ensure they get to dine where they preference is. The new dining room experience is being enjoyed by residents and while initially planned for lunchtime as the service has established the residents feedback shows they enjoy same a quality improvement initiative is being planned and will introduce this dining room for the evening meal.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The fire folder has been updated. Staff have been spoken to about the practice of wedging open fire doors and same is being monitored by management. Additionally, this finding has been added to the safety pause to ensure all staff continue to adhere to instruction of not using same. Magnet holders have been requested, approved and ordered. Fitting of same is awaited All PEEPS have been updated with identifying photographs	
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 identified care plan has been updated with the most up to date information to inform individualized care post admission to the acute care setting	

Regulation 7: Managing behaviour that is challenging	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: The National Clinical Guidelines No.21 training on non-cognitive symptoms of dementia is currently being delivered at ward level to all team members. The training will support team members understanding and knowledge of behaviours that challenge. The care plan of the identified resident has been reviewed and updated.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: An example of an activity schedule operating in the hospital includes music, art, bingo, dog visiting, Zumba, games for life. Management will continue to ensure this schedule is enhanced and residents are facilitated to avail of activities An existing quality improvement plan in place in Module 2 to facilitate more meaningful time with residents is being implemented in Module 3. This plan ensures increased periods of time where residents can avail of activities. The activity schedule is visible to all residents. It ensures that in the evening staff can further engage and interact with residents and attend to their social needs, this in turn encourages residents to stay up for longer. Management and staff ensure that life in West Kerry Community Hospital is closely linked with community activities to enhance the wellbeing of our residents. i.e. Outings for ice cream, visits to Ocean world, walks by the Marina, trip to newsagents, visiting the Nuns gardens. Discussions with the catering personnel is planned to ensure adequate refreshment rounds are in place and to enhance these occasions on a social level by including article reading and general chat. Efforts has also been made to secure funding for an activities coordinator to further promote mental and physical health, reduce stress, and support personal identity so that every resident can thrive	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	27/10/2025
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	29/09/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	29/09/2025
Regulation 23(1)(a)	The registered provider shall ensure that the	Substantially Compliant	Yellow	01/09/2025

	designated centre has sufficient resources to ensure the 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	30/09/2025
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.	Substantially Compliant	Yellow	27/10/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	26/07/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the	Substantially Compliant	Yellow	01/07/2025

	information set out in Schedule 1.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	27/10/2025
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	27/10/2025
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	17/06/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate	Substantially Compliant	Yellow	27/10/2025

	to their role, to respond to and manage behaviour that is challenging.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	17/06/2025
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Not Compliant	Orange	29/08/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	29/08/2025
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	29/08/2025
Regulation 9(3)(b)	A registered provider shall, in	Not Compliant	Orange	29/08/2025

	so far as is reasonably practical, ensure that a resident may undertake personal activities in private.			
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