



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:	25 March 2026
Centre ID:	OSV-0000569
Fieldwork ID:	MON-0050073

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 18 single, ten twin and two 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:	44
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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
Tuesday 24 March 2026	15:00hrs to 19:45hrs	Ella Ferriter	Lead
Wednesday 25 March 2026	08:55hrs to 15:55hrs	Ella Ferriter	Lead
Tuesday 24 March 2026	15:00hrs to 19:45hrs	Siobhan Bourke	Support
Wednesday 25 March 2026	08:55hrs to 15:55hrs	Siobhan Bourke	Support

What residents told us and what inspectors observed

This was a two day unannounced risk inspection by two inspectors, carried out in response to an increase in safeguarding incidents reported to have occurred in the centre. Over the two days, inspectors greeted all residents living in West Kerry Community Hospital, either in their bedrooms or in the communal areas. The inspectors also spent time observing residents' daily lives and care practices in the centre, in order to gain insight into the experience of those living there. All residents spoken with, 19 in total, were complementary about the healthcare they received. They told inspectors that they were "well looked after" and that they were happy to be living in the centre. However, some residents made references to staff rushing and telling them they were very busy, if they rang their bell and others stated that while some staff were exceptionally kind and approachable, a few were not. Inspectors also observed institutionalised practices over the two days, such as residents remaining in their beds for the majority of the day, limited social stimulation, limited use of the communal rooms, and residents referred to as patients, as opposed to residents living in their own home.

West Kerry Community Hospital is a designated centre for older people situated in the town of Dingle in West Kerry. The centre is located in a Gaeltacht area, which has one of the largest Irish speaking communities in the country. There were 44 residents living in the centre on the days of this inspection and two empty beds. Operationally, residents' accommodation in the centre was divided into two units called Ionad Bhreannainn and Ionad Eibhlis. Inspectors noted that staff referred to resident accommodation areas of the centre as Module 2 and Module 3, and the Irish names were not in use. There was also one other area of the centre called Module 1, its entrance in close proximity to the front door. The bedrooms in this unit were not currently registered for use by the provider, and were adjacent to office spaces allocated for the local public health nursing services. There was additional community public services located on a corridor beyond the residents' sitting room. Over the two days, in this foyer area, inspectors saw members of the public entering the building and accessing public health facilities and a day care service. However, there was no system in place to monitor who was entering the designated centre. For example; there was no person assigned to reception, no requirement to sign in a visitors log and there was not a system in place to ensure the door was locked in the evening. This finding is further detailed under Regulation 23.

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 dining and visitors room had recently been refurbished and were seen to include modern decor and furnishings. Inspectors were informed that there were plans in place to upgrade the decor in the sitting room in the coming months, with support from the local Friends of West Kerry Community Hospital charity group. These communal rooms were located a considerable distance away from the residents' living accommodation and

many residents would require support from staff to access these areas. On arrival to the centre, inspectors observed two residents in the sitting room playing games at a table, and on day two there was a group music and chair exercise session for six residents in this room. Observations of the inspectors over the two days was that with the exception of seven residents attending the dining room at lunch time, there was limited use of the communal rooms outside of Ionad Bhreannainn and Eibhlis and it was custom and practice for residents to remain in their bedrooms for the majority of the day. This finding and other findings in relation to care practices observed, are actioned under Regulation 9: Residents Rights.

The inspectors spent time over the two days observing resident and staff engagement. The inspectors found that staff interactions with residents were seen to be generally kind. Some residents and staff spoke Irish when they greeted each other and staff spoken with knew residents care requirements. Residents looked well-groomed and those who spoke with the inspectors confirmed that they were happy living in the centre. Some residents were attending for respite (short stay) and they stated they were made welcome by staff. Residents told inspectors they knew the managers and staff and enjoyed chatting with them about local affairs. Some residents commented about the noise levels from bells ringing throughout the day. Inspectors also noted that bells were particularly loud and disruptive.

From discussions with staff and management it was evident that resources had been allocated since the previous inspection, to provide a programme of activities for residents. On the two days of this inspection there was a member of staff allocated to activities. On day one of the inspection, they had accompanied a resident to a local hotel for a coffee and on day two they were seen facilitating a group exercise session in the morning and an arts and crafts session with a small group of residents in the afternoon. However, over the two days many residents were seen to have minimal social stimulation outside of when care was being delivered. Staff who spoke with the inspectors did not perceive activities or social stimulation as part of their role.

The inspectors spent time observing the dining experience for residents. Inspectors observed that on both Ionad Bhreannainn and Eibhlis there were dining tables situated beside an exit door, off the corridors. A few residents were observed having their meals in this area over the two days. However, inspectors noted that these were not inviting spaces and there was no privacy or dignity for residents in these areas, as they were effectively on a corridor. Noise levels during the mealtimes was also not conducive to a good dining experience as housekeeping staff were cleaning rooms and corridors, while residents were eating their meals. Inspectors saw signage at the nurse's station directing staff as to what residents should be brought to the main dining room on the day. This practice did not support residents' rights and choice. Findings in relation to the choice of dining experience for residents is further detailed under Regulation 9: Residents Rights. Residents spoken with were very complementary about the quality of the food they received and informed the inspectors that they always had a choice.

In general, visitors spoken with, six in total, stated that they were happy with the care the loved one received. They informed inspectors that visiting was encouraged

and there were no restrictions in place. Inspectors noted that there was one visitor's room located on Ionad Eibhlis, however, this had been converted into a storage room. Therefore, residents, many of whom resided in shared accommodation, no longer had access to this private space to meet with visitors or sit in themselves. A review of residents and family surveys found that this feedback, with regards to not having access to private space for visiting, had recently been provided. This is actioned under Regulation 23 and 9.

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

Findings of this inspection were that the management systems in place in the centre were not effective and did not provide assurance that there was appropriate oversight of the services provided to residents. The high levels of non-compliance found on inspection, posed a risk to the safety and wellbeing of residents. Significant action was required to comply with the regulations pertaining to protection, residents' rights, training and supervision of staff, complaints management, and the notification of incidents, the use of restraint and governance and management. These findings will be detailed under the relevant regulations of this report.

As mentioned in the first section of this report, this risk inspection was carried out in response to concerns pertaining to the management of safeguarding incidents in the centre, which the Chief Inspector had been statutorily notified. On receipt of this information inspectors held a cautionary meeting with the registered provider on the 10th of March 2026, where commitments were given to address the safeguarding incidents and enhance the governance and management arrangements in the centre. However, findings of this inspection were that the provider had failed to implement the actions they committed to and inspectors were not assured that there were appropriate systems in place to safeguard residents.

West Kerry Community Hospital is a designated centre for older people, operated by the Health Service Executive (HSE), who is the registered provider. 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. There had been a change in person in charge since the previous inspection and they were in post for six months, at the time of this inspection. They worked full time in the centre and were supported in their management role by a clinical nurse manager. There was also a team of registered nurses, (RGNs), health care attendants (HCAs), cleaning, catering, activities, and maintenance staff. As a national provider involved in operating residential services for older people, this designated centre also benefits

from access to and support from centralised departments such as human resources, fire and estates and practice development. There was clear lines of accountability and responsibility, however, the inspectors found that these were ineffective.

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 restrictive condition remained on the centres registration. Although the provider had recently notified the Chief inspector of the appointment of a PPIM, the relevant documentation was not all in place to progress.

On the day of the inspection there were adequate numbers of nurses and healthcare staff employed to care for residents. Night time staff allocated is one nurse and one healthcare assistant on Ionad Bhreannainn and Ionad Eibhlis. Inspectors noted that this would not be adequate when considering the size and layout of the premises, particularly if residents were supported to use the communal space in the evening after 8pm. However, this was not encouraged or facilitated, as the majority of residents were seen to remain in their bedrooms for the day. This is further detailed under Regulation 15: Staffing.

Inspectors were informed that mandatory training included fire safety, safeguarding vulnerable adults, and infection control, people moving and handling and the management of responsive behaviours. However, it was difficult to determine staff attendance at training, as training records only listed two of the five trainings. Findings of this inspection were that the training and supervision of staff was inadequate to ensure they delivered person-centred care, understood residents rights and that residents were safeguarded. This is further detailed under Regulation 16: Training and Staff Development.

While there were systems in place to record incidents involving residents, via the HSE National Incident Management System (NIMS) the inspectors found that the incident reporting system was not effective. On review of incident records, three notifications had not being submitted to the Chief Inspector, within two days, as per regulatory requirements and multiple incidents had been submitted late. Incidents in relation to safeguarding were also not managed in accordance with the HSE's policies for the centre and there was inadequate oversight of these incidents by management. These findings are actioned under Regulation 23 and 31.

There was a quality management system in place which included an electronic audit system for 2026, to monitor the service delivery. Although records for some of these audits were available for review, improvement action plans were not consistently developed or subject to time frames, which meant that some deficits and issues

were not addressed. Overall, there were limited processes in place to oversee the quality and safety of the service and ensure good levels of regulatory compliance.

Residents' records were reviewed by the inspectors who found that they complied with Schedule 3 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Records were stored securely and were readily accessible. A review of staff personnel files evidence that each staff member had a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021 and registered nurses had on file their professional registration. However, one staff file reviewed did not have all required information available and there was not appropriate records maintained in relation to people entering the designated centre and to monitor training. These and other finding in relation to records are actioned under Regulation 21.

The management of complaints was not robust. Inspectors found that complaints from residents and visitors were not always recorded or managed in line with the centre's policy and expressions of dissatisfaction submitted verbally or in writing to the registered provider, had not been logged as complaints. Additionally, feedback from residents and visitors did not assure inspectors that action plans developed in response to complaints were implemented in a timely manner, such as delays in care delivery. This finding is detailed under Regulation 34; Complaints Procedures.

Regulation 15: Staffing

From an examination of the staff duty rota it was the found that 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. This did not support residents having choices and a social model of care delivery.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The registered provider had inadequate arrangements in place to ensure appropriate levels of staff supervision were in place. This lack of staff supervision, monitoring and support had a direct negative impact on the delivery of health and social care to residents. This was evidenced by the following findings:

- Where enhanced supervision of staff was indicated, and where numerous safeguarding concerns were being investigated, there were not effective supervision plans developed and implemented. This posed a risk to residents.

- There was not adequate supervision of care delivery, specifically this related to ensuring that residents' rights were upheld. Inspectors observed institutionalised practices and these practices had not been recognised, monitored or addressed. These are repeat findings of inspections of June 2022, August 2023, July 2023 and June 2025 and were embedded in the day to day running of the centre.

The inspectors found action was required pertaining to the delivery of training, for example:

- Findings of this inspection would indicate that training was required for staff with regards to residents' rights, person-centred care and the delivery of a social model of care, to equip staff to prioritise residents individual needs, dignity and autonomy over staff routines.
- There was a lack of oversight of staff training as there was no system in place to monitor staffs attendance at all mandatory training.
- Staff were not knowledgeable regarding the national policy on restraint, as evidenced by the large amount of inappropriate restraint practices in use.

Judgment: Not compliant

Regulation 21: Records

Records were not in line with the requirements of the regulation evidenced by the following findings:

- The staff training record was incomplete. This meant that the provider could not provide assurance that all staff had received training, commensurate to their role.
- One staff members personnel file did not contain the necessary information, as required by Schedule 2 of the regulations, such as a full employment history, documentary evidence of any relevant qualification and evidence of the persons identity.
- Records pertaining to adverse incidents involving residents were not complete. For example, not all recorded incidents contained actions taken by staff, contributing factors, a risk assessment, results of an investigation and actions taken.
- A directory of visitors was not being accurately maintained. This is a requirement under Schedule 4.

Judgment: Not compliant

Regulation 23: Governance and management

Governance and management systems in place were not effective, to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This is evidenced by the following findings:

- There was a lack of oversight of safeguarding in the centre. The management systems in place to recognise and respond to safeguarding incidents did not ensure that these were acted upon in a timely manner or investigated in line with the registered provider's safeguarding policy.
- There was inadequate supervision of staff and where enhanced supervision was indicated, this was not effectively implemented or monitored, which posed a risk to residents.
- The incident management systems were weak. This was evidenced by the delay in reporting and recognising safeguarding notifiable incidents, as well as incidents such as medication errors, not being used to learn from and to improve the service.
- There was ineffective communication systems in place, to ensure that senior management in the HSE had effective oversight of the service. Additionally, where safeguarding concerns were escalated to senior management there was not evidence that these were acted on. This posed a risk to the delivery of a safe service.
- The provider was in breach of condition one of its current registration. This specifically related to the change of function of a visitors room into a storage space for equipment.
- The audit system was not effective in identifying areas for improvement as identified on this inspection. The service was not monitoring or recording key clinical performance indicators, such as the use of restraint, dependency levels of residents, the number of wounds, and infections.
- Workplace policies and procedures had not been appropriately followed and implemented and there was inadequate oversight from senior management, where these were required to be actioned.
- There was not a system in place to monitor people entering the designated centre such as visitors and 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 nomination of a person participating in the management of the centre, the relevant documentation was not complete, therefore could not be progressed.

Judgment: Not compliant

Regulation 31: Notification of incidents

Significant action was required in relation to the incident management systems evidenced by the following findings:

- From a review of records and via observations of the inspectors it was noted that three statutory notifications had not been submitted to the Chief Inspector within the required two day time frame, as stipulated in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. These related to an outbreak of any notifiable disease, any incident of alleged or confirmed abuse and a serious incident to a resident, which required hospital admission.
- A number of notifications had been submitted prior to this inspection that were delayed. This ranged from six to 64 days late. These incidents are required to be notified to the Chief Inspector in writing within two days of occurrence.
- The notification of quarterly restrictive practice notifications were found to be inaccurate as they did not accurately reflect the number of residents allocated bedrails and the number of wander guards in use.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of records found that complaints were not managed in line with the requirements of the regulations. For example:

- While a log of complaints were maintained on each module, these did not include all complaints or concerns raised by residents and relatives.
- Feedback from residents regarding poor care delivery was not recognised or investigated as complaints.
- The policy on the management of complaints was generic and did not include centre specific detail in relation to the complaints officer and the review officer.
- The registered provider had not ensured that the nominated complaints officer had received suitable training to deal with complaints, in accordance with the designated centres complaint's procedures.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that although residents had good access to healthcare and reported they were content in the centre, the quality and safety of care provided to residents was compromised, as a result of ineffective systems of governance and management described in the first section of this report and inadequate oversight of safeguarding. Significant actions were required in relation to safeguarding, resident's rights, and the use of restrictive practices, to ensure the quality and safety of the service provided to residents living in West Kerry Community Hospital.

Residents' care plans and daily nursing notes were recorded using a paper based system. The inspectors reviewed a sample of residents' assessments and care plans. Although it was evident that staff were familiar with residents clinical care needs and were seen to appropriately implement the care plan, some care plans required to be updated to reflect the current care requirements of residents. These findings are detailed under Regulation 5.

Inspectors were assured that residents' health care needs were met to a high standard. General practitioners attended the centre five days a week and residents were supported to access external services as required. The physiotherapist attended twice weekly and there was access to occupational therapy, as well as dietitian and speech and language therapy. Residents were seen to have access to a range of assistive equipment, including specialised seating, overhead hoists and electric wheelchairs.

Staff working in the centre had received safeguarding training. However, the registered provider had not taken all reasonable measures to protect residents. Specifically, safeguarding incidents had not been investigated as per the HSE policy and protective measures put in place, to mitigate risk, were not effective to keep residents safe. These findings are further detailed under Regulation 8: Protection.

Significant improvements were required in the use of and monitoring of restraint within the centre. There was a high use of restrictive practice, particularly bedrails observed to be in use, as well as a number of residents having more than one restrictive practice in use at any given time. Although there was a register of restrictive practices maintained on each unit, these were found to be inaccurate. This is detailed further under Regulation 7: Managing behaviour that is challenging.

Residents were provided with wholesome and nutritious food choices for their meals and snacks and gave positive feedback in relation to the food. Menus were developed in consideration of resident's individual likes, preferences and where necessary, their specific dietary or therapeutic diet requirements, as detailed in the resident's care plan. However, as described in the first section of this report, there was limited access to a dining experience for residents living in the centre, which is actioned under Regulation 9: Residents Rights.

Residents had access to information and local Kerry newspapers, and Wi-Fi was available. Residents had access to advocacy services and were consulted in relation to the running of the centre monthly. Although the healthcare needs of residents

were met to a good standard the social care needs of residents did not receive adequate attention, to ensure that they were adequately stimulated and had variety to their day. Inspectors observed institutional practices over the two days which did not protect and promote residents autonomy, independence and choice, which are detailed under Regulation 9: Residents Rights.

Regulation 17: Premises

Action was required to ensure the premises conformed with the matters set out in Schedule 6, evidenced by the following findings:

- There was inappropriate storage of equipment such as chairs in shared bathrooms. Therefore, this may make access to these facilities difficult for residents.
- The layout of some of the twin bedrooms did not ensure that residents had access to a locker beside their bed or could view the television.
- Some multi-occupancy bedrooms had single wardrobes, therefore, space for residents clothing was limited. A residents reported they would send clothes home to their family to store, as there was not enough room to store them.
- Some bedroom doors were covered in a plastic film which was observed to be cracked and peeling.
- As referenced earlier in the report, the visitors room on Ionad Eibhlis had been converted to a storage room. Therefore, the registered provider had not ensured that the centre was operating in accordance with the statement of purpose, for which it had been registered.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

A review of the nutritional aspects of the service found that there were good arrangements in place to ensure residents, assessed as being at risk of malnutrition received care and support in line with their assessed care needs, and the recommendations of health care professionals. Residents were provided with a choice at mealtimes and were served food that met their individual needs and dietary requirements, including modified consistency diets, as prescribed by health care professionals.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While some care planning documentation reviewed demonstrated comprehensive knowledge of residents' individualised needs, some further actions were required evidenced by the following findings:

- A resident who had required wound care treatment did not have sufficient detail in their skin integrity care plan to direct care delivery. Specifically, this related to the frequency of wound dressings and use of clinical assessment tools and photographs.
- While validated tools were being used to assess clinical risk, they were not always reflected in care plans. For example: where a residents risk of pressure ulcer development had increased, this was not referenced in their skin integrity care plan.
- One residents care plan was reviewed after six months, where as the regulatory requirement is at intervals not exceeding four months.

Judgment: Substantially compliant

Regulation 6: Health care

The inspectors found that residents had access to appropriate medical and allied health and social care professional support to meet their needs. Residents had a choice of general practitioner who attended the centre as required or requested. Residents were also supported with referral pathways an access to allied health and social care professionals. There was a low incidence of pressure ulcer development in the centre and there was one resident being treated for a pressure ulcer on the day of this inspection.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre did not meet the requirements of this Regulation evidenced by the following findings:

- Bedrail risk assessments were inconsistently completed and the number of residents observed to have bedrails in use did not correlate with the register maintained in the centre.
- Where a resident had capacity to consent and it was documented that bedrails requested, documentation was signed by family as opposed to the resident. This was contrary to the centres policy and did not respect residents rights.

- 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.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to take reasonable measures to protect residents from abuse and to adhere to their own policy on safeguarding vulnerable adults from abuse. This was evidenced by the following findings:

- Inspectors found that a number of allegations and incidents of abuse that impacted the safety and welfare of residents were not being appropriately investigated and managed as per the centres policy. Appropriate action was not taken, in a timely manner, to ensure that residents were protected.
- Where safeguarding risks were identified, the reported protective measures put in place by the provider failed to protect residents, as evidenced by the continuance of the safeguarding risks to residents.
- Furthermore, an allegation of neglect was not recognised as a safeguarding incident and therefore not reported or managed, in line with the regulations.

Judgment: Not compliant

Regulation 9: Residents' rights

As found on the previous inspections of the centre significant action was required to ensure residents rights were upheld in the centre and institutionalised practices were not embedded in the day to day life of residents. This was evidenced by the following findings:

- Residents were not facilitated and encouraged to use communal space outside of Ionad Bhreannainn and Ionad Eibhlis. Residents choice in relation to access to the dining room was restricted, as there was only one sitting for residents at meal times, with space for approximately ten residents in the dining room. Therefore, many residents did not have access to a proper dining experience. The use of dining tables, off the main corridors, did not ensure residents privacy and dignity was respected while eating.
- The inspectors observed high levels of noise in the units during the lunch time meal and a number of residents complained to inspectors regarding the volume of noise from call bells and sensor alarms, which impacted their quality of life.

- As found on previous inspections institutional practices were observed such as residents remaining in the bedroom for the day and being referred to as patients.
- The change of function of the visitors room on Ionad Eibhlis, to a storage room resulted in residents, 65% of whom resided in shared accommodation, not having facilities in close proximity to meet their family in private. There was not evidence that this decision had been made in consultation with residents. This did not respect residents choice.
- The activities programme was reviewed and was found to be very limited. The inspectors observed that residents spent a considerable amount of time with minimal stimulating activity over the two days, the majority of residents spending the day in their bedroom, or lying on their bed. 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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	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	Not compliant
Regulation 9: Residents' rights	Not compliant

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

Inspection ID: MON-0050073

Date of inspection: 25/03/2026

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	Substantially 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 Staffing Enhancements – Business Cases Progressed The Person in Charge has progressed the following business cases to further strengthen staffing provision within the designated centre: • Additional HCA Night Duty: 2.58 WTE approved to enhance evening and night-time support. • Activities Coordinator: 1.79 WTE approved to support meaningful activities and social engagement for residents. • Clinical Nurse Manager II (CNM II): Recruitment is currently underway to replace two vacant CNM II posts, ensuring appropriate clinical leadership, supervision, and oversight within the centre. 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 has been initiated for Clinical Nurse Manager II (CNM II) posts within the designated centre. These appointments will enhance clinical supervision, monitoring, and oversight, and will support the safe and effective delivery of health and social care to residents. • Training needs analysis is being undertaken and training matrix developed. • Local management has implemented daily walk throughs of all units to monitor care practices and to ensure that institutionalised practices are identified and addressed promptly. This includes providing informal on-the-spot coaching, help staff rethink task-based habits, support problem-solving. Safeguarding Measures • Enhanced safeguarding plans have been implemented in respect of staff members involved in allegations of abuse Person Centred Care and Residents' Rights • A person centred approach to care is being actively implemented across the designated centre. • Staff are undertaking training in person centred care, reinforcing the prioritisation of residents' dignity, autonomy, choice, and individual preferences over routine led practices. • A bed rail review has been completed, and all identified actions have been fully implemented, ensuring the use of bed rails is appropriate, assessed, and reflective of residents' needs and rights. • New admissions who have consented and been risk assessed for use of restraints are highlighted at safety pause to inform staff. Robust assessment and consent processes put in place for new admission in relation to restrictive practice. Education and Training The Person in Charge has arranged and overseen a comprehensive programme of education to support staff knowledge, practice, and compliance: • CNM 2 currently undertaking designated safeguarding officer training. • Safeguarding awareness will be encompassed into new staff induction pack for West Kerry Community Hospital. • All staff will be completing the four online modules on "Applying a Human Rights Based Approach to Health and Social Care." • A schedule of person centred care education sessions has commenced for all staff within the centre. • All care staff are completing education on "The Fundamentals of Advocacy in Health and Social Care." • Restrictive practice education has been organised to support staff understanding of the national policy on restraint and the appropriate use of restrictive practices. • A new bespoke training matrix has been implemented within the centre to monitor	

attendance at all mandatory and role specific training. This ensures training records are up to date, clearly visible, and readily auditable at all times.

- Informal monthly case study training sessions being delivered by visiting consultant gerontologist, focused on residents of West Kerry Community Hospital – care plan and specific care needs will be discussed and explored with multi-disciplinary team.

These actions demonstrate the Registered Provider's ongoing commitment to safeguarding residents, strengthening governance and supervision, and embedding a rights based, person centred culture of care within the designated centre.

Regulation 21: Records

Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

Records Management, Training Oversight and Governance Systems

A new training matrix has been implemented within the designated centre to monitor all staff attendance at mandatory and role specific training. This system ensures that all training records are current, clearly visible, and readily auditable at all times, supporting effective oversight and regulatory compliance.

The identified staff member's personnel file identified on inspection has been reviewed and updated to ensure it contains all information required under Schedule 2 of the Regulations. In addition, a standardised personnel file checklist has been implemented to ensure that all staff personnel files consistently comply with Schedule 2 requirements. These measures ensure that incident recording is comprehensive, transparent, and supports learning, governance, and quality improvement.

The Person in Charge has reviewed and strengthened practices relating to the directory of visitors.

A member of the administration team has been assigned responsibility for monitoring the visitors' register to ensure it is maintained in line with the requirements of Schedule 4 of the Regulations.

Visitor Access, Reception Cover and Environmental Controls

The Person in Charge is implementing systems to ensure appropriate reception cover is in place and that clear signage is available to support visitors to sign in on arrival to the designated centre.

Residents' families have been formally communicated with to reinforce the requirement for all visitors to sign in when attending the designated centre.

A design team, in collaboration with estates colleagues, has been established to review and redesign access arrangements within the campus. This work aims to ensure the designated centre is not openly accessible to other services operating from the site, with the establishment of separate access points for those services. These measures will reduce unnecessary public footfall and enhance the safety and security of residents.

Incident Management and Quality Governance

An Incident Tracker has been developed and implemented within the designated centre. All incidents are now recorded on this tracker, with actions documented, monitored, and reviewed to completion.

Details as below are captured on the tracker: Initials of Service User Date of Incident Brief Description Incident Date NIRF Submitted Category of Incident NIRF Ref Number Date PAF Submitted QPS PAF Status SIMT Date Decision at SIMT Any Recommendations Notes/Comments Status of Cases Consideration to I.E HIQA, Safeguarding Required Notification: Y/ N Local Quality, Patient Safety (QPS) meetings are being established within the location. The Person in Charge will be supported by the regional QPS team to develop and embed a robust QPS governance structure within WKCH. These meetings will provide structured oversight of incidents, complaints, safeguarding concerns, and associated risks, and will support continual monitoring, escalation, and learning. QPS Training Sessions delivered immediately: • 14 04 2026 – Bespoke Enterprise Risk Management Training completed with WKCH Management • 15 04 2026 – Enterprise Risk Management Risk Register Training • 16 04 2026 - HIQA Notification Session onsite with WKCH Management • 29.04.2026 – Serious Incident Management Training with WKCH Management • Incident Management Framework Training for staff – QPS to provide rolling training course of same for staff one day a month onsite	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance, Management and Oversight Arrangements The Person in Charge has implemented the following measures to ensure that governance and management systems provide a safe, appropriate, consistent, and effectively monitored service to residents within the designated centre.	

Safeguarding and Risk Management

- Enhanced safeguarding plans have been implemented in respect of staff members involved in allegations of abuse.
- All safeguarding incidents, complaints and HIQA notifications within the designated centre have been reviewed, appropriate safeguarding plans have been implemented and reviewed in conjunction with the HSE Safeguarding Team.
- Safeguarding training has been arranged for management within the designated centre to strengthen knowledge, accountability, and preventative practices.
- Trust in Care processes are progressing in cases where preliminary screening has indicated same.

Incident Management, Notifications and Quality Governance

- An Incident Tracker has been developed and implemented. All incidents within the designated centre will be recorded on this tracker, with associated actions documented, monitored, and reviewed to completion.
- Education sessions have been delivered to management within WKCH regarding HIQA notifications, including statutory requirements and notification timelines. Prompt sheet has been designed to capture incidents to report onwards on a quarterly basis.
- Local Quality and Patient Safety (QPS) meetings are being established. The Person in Charge is supported by the regional QPS team to embed a robust QPS governance structure within WKCH, providing structured oversight of incidents, complaints, safeguarding matters, and associated risks.

Reporting Structures and Senior Management Oversight

- The implementation of Integrated Health Areas (IHAs) has been established since March 2026 in IHA Kerry.
- Within Community Healthcare Area 2 (Tralee and West Kerry), the designated centre has established clear reporting lines to senior management, including the CHA 2 General Manager (PPIM), the IHA Services Lead, and the IHA Management Team.
- These arrangements enhance operational oversight and senior management engagement, strengthening governance and accountability for designated older persons' residential facilities within the area.

Environment, Privacy and Visitor Management

- The visitor room in Ionad Eibhlis has been reinstated, ensuring residents in shared accommodation have access to a private space, located in close proximity to their living area, to meet with family and visitors. All non essential items previously stored in this room have been relocated to an appropriate alternative location.
- Systems are being implemented to ensure appropriate reception cover is in place and that improved signage supports visitors to sign in on arrival.
- Residents' families have been formally communicated with to reinforce the requirement to sign in when visiting the designated centre.
- A design team, in collaboration with estates colleagues, has been established to review site access arrangements. This work aims to ensure the designated centre is not accessible to other services operating on the campus, with the development of separate access points to reduce public footfall and enhance resident safety.

Audit and Monitoring Systems

- The management of the clinical audit system within the centre has been reviewed.

- All clinical audits are now overseen by nursing management and identified deputising senior nurses, ensuring that non compliances are identified, actioned, monitored, and resolved in a timely manner.
- Education on the audit system has been arranged for the nursing team on 5 May 2026, to support consistent implementation and follow through.

Regulatory Notifications

- All required documentation has been submitted to HIQA, and PPIM Fitness Interviews have been scheduled.

Regulation 31: Notification of incidents

Not Compliant

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

Statutory Notifications, Oversight and Support Arrangements

The 2 statutory notifications have been submitted to the Chief Inspector in accordance with the requirements of Schedule 4 of the Health Act 2007.

A Statutory Notifications Reference Folder is being 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 between the Director of Nursing in WKCH and an experienced Director of Nursing. This mentorship provides structured professional support, guidance, and governance oversight, particularly in relation to regulatory compliance and management responsibilities.

The new monitoring record for restrictive practices has been implemented within the centre. This record supports nursing management to:

- Monitor and review the use of restrictive practices,
- Ensure compliance with national policy, and
- Facilitate the accurate and timely submission of quarterly restrictive practice notifications.

These measures strengthen governance systems, enhance regulatory compliance, and support effective management and oversight within the designated centre.

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Complaints Management and Oversight A robust complaints monitoring process has been implemented across both wards within the designated centre. The previous system for forwarding complaints to the Director of Nursing (DON) has been reviewed and strengthened. To support confidentiality and accessibility, a standardised individual complaints recording form is now used. Completed forms are submitted to the DON in a timely manner for review and appropriate action. All complaints are escalated and managed by the DON in accordance with the centre's complaints policy and procedures. A single, centralised complaints log is maintained for the designated centre to ensure effective oversight, trend analysis and governance. All feedback received is formally communicated to the Person in Charge, reviewed, and actioned as appropriate, ensuring consistent oversight and timely responses. The Person in Charge has received supplementary complaints process support from the Regional Service Feedback Manager, further strengthening knowledge and consistency in the management of complaints in line with policy and regulatory requirements. Staff awareness has been reinforced to ensure that all expressions of dissatisfaction or feedback from residents in relation to poor care delivery are appropriately recognised, escalated, and managed as complaints, in accordance with the centre's complaints policy. Centre specific information relating to the nominated complaints officer and review officer has been added to the complaints policy, ensuring clarity for residents, families, and staff regarding the complaints process. The Registered Provider has ensured that the nominated complaints officer has received appropriate training to manage complaints effectively, in line with the designated centre's complaints policy and regulatory requirements.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: All equipment previously stored inappropriately has been relocated to a designated storage area within the designated centre. No communal or resident care areas are now used for storage, ensuring that all shared spaces are maintained for their intended purpose and are safe and accessible for residents. The visitor room in Ionad Eibhlis has been fully reinstated to provide residents in shared accommodation with access to a private space, located in close proximity to their living area, to receive visits from family and friends. All items previously stored in this room have been removed and relocated to an appropriate storage location, restoring the room	

to its intended use.

03.06.2026

Locker

- To address the matter of the room layout not ensuring that residents have access to a locker beside their bed, the provider has reviewed the overall floor space and room layout. A premise improvement plan has been initiated.
- Measures have been implemented to prioritise the residents having easy access to personal belongings, this involves removing oxygen ports where they are unused which allows for the screens to be folded in a more compact fashion.
- Ongoing monitoring through daily management walk-rounds to ensure compliance is sustained have been introduced.
- Expected date to action these shortfalls: Immediate.

Television

- Individual arm-mounted bedside televisions are being negotiated for each resident occupying a twin bedroom. The televisions will be positioned to allow independent adjustment and viewing from each resident's bed space, ensuring equitable access to television and other media services.
- Expected date to action this shortfall: 4 months (October 2026)

Wardrobes

- A review of the affected bedrooms has been completed, and an improvement plan has been developed. While the purchase of 28 new wardrobes has been recently fulfilled, a request for a further 10 new wardrobes will ensue. The approval of this request will ensure that all continuing care and respite residents are supported to safely store personal clothing and possessions, personalise their living environment, and enhance privacy, dignity and quality of life.

Expected date to action these shortfalls: 4 months
(October 2026)

- In the interim, staff are being encouraged to offer additional storage options to residents where feasible, staff are advised to support residents to access and organise personal belongings in a manner that promotes dignity and choice, and to facilitate requests in terms of having their individual preferences catered for.

Expected date to action this shortfall: Immediate

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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 has ensured that the identified resident's skin integrity care plan has been reviewed and updated to include individualised, resident specific information to effectively direct care delivery. The updated care plan, and associated wound assessment (form 020) and Dressing Record and Evaluation (form 020a) clearly outlines: dated care plan clearly outlines: • The frequency and type of wound dressings, • The use of appropriate clinical assessment tools, and • The use of clinical photographs, where indicated, to support ongoing monitoring and evaluation. A centre wide review of skin integrity care plans and associated validated assessment tools was undertaken by the nursing team, supported by clinical audit. Where gaps were identified, care plans were reviewed and updated to ensure: • Risks for pressure ulcer development are clearly documented, and • Appropriate preventative and responsive interventions are clearly outlined within each resident's skin integrity care plan. Nursing staff are completing 'Care Planning with Older Persons' education, reinforcing best practice in individualised, person-centred care planning. A wound care management educational support resource has been developed and implemented to guide the nursing team on the documentation requirements and forms to be completed when undertaking wound care practices. Onsite education was arranged and is being delivered to the nursing team on wound care management, assessment, and monitoring, in line with the HSE National Wound Care Guidelines (2018). This training was delivered onsite on Monday, 27 April. The Person in Charge has liaised with all nursing team members to reinforce the importance of: • Maintaining contemporaneous, individualised person centred care plans, and • Complying with the legislative requirement to formally evaluate and review care plans at intervals not exceeding four months. The identified care record that was outside the required regulatory review timeline has been reviewed and updated. A centre wide review of all resident care records was subsequently undertaken to ensure compliance with regulatory review timeframes. To support sustained compliance, nursing management has introduced a Formal Evaluation and Review Schedule to guide and support the nursing team in meeting regulatory timelines. This schedule is monitored weekly by nursing management, providing assurance that care plans are reviewed, evaluated, and updated in a timely manner.	

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: All bed rail risk assessments within the designated centre have been reviewed and updated by nursing management. This centre wide review was supported by clinical audit, and areas for learning were identified and addressed through targeted educational supports. The number of residents with bed rails in use has been reviewed and verified. This information now accurately correlates with the bed rail register maintained within the centre, ensuring consistency between clinical practice and records. To support sustained compliance, an educational resource has been developed and shared with the nursing team. This resource reinforces appropriate bed rail use and documentation requirements, including the accurate maintenance of the bed rail register. Nursing management will provide ongoing supervision and surveillance to ensure compliance is embedded in practice. The Person in Charge has implemented a new training matrix within the centre to ensure that all staff training and education are clearly recorded, visible, and auditable at all times. In addition, training in the management of responsive behaviours has been completed on 22.04.026 arranged for all team members to support safe, least restrictive care practices. The Person in Charge has liaised with the nursing team to reinforce the importance of adherence to the centre's consent policy. A review of all bed rail consent forms was undertaken by nursing management and amended where required to ensure compliance with the HSE National Consent Policy (2024). New falls prevention system being procured to monitor residents at risk of falling. An additional educational resource was compiled and shared with the nursing team to support understanding of consent requirements and decision making in relation to the use of bed rails. Ongoing compliance will be monitored through regular clinical audit, with oversight provided by nursing management to ensure practice remains aligned with policy, legislation, and national guidance. The Person in Charge has installed a new training matrix to ensure the staff training and education completed within the centre is available, clearly visible and auditable at all times. In addition, training in the management of responsive behaviours has been scheduled for all team members	

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The Registered Provider has implemented the following measures to protect residents from abuse, in accordance with the Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures: • The Person in Charge has ensured that all allegations and incidents of abuse are being managed and investigated in line with the designated centre's safeguarding policy and national safeguarding procedures. Immediate and ongoing actions have been implemented to ensure that residents' safety, welfare, and protection are maintained at all times. • The referenced safeguarding incident has been formally reported to the HSE Safeguarding Team and is currently under review in line with the appropriate safeguarding processes. The required statutory notification has also been submitted to HIQA. • Enhanced safeguarding plans have been implemented in respect of staff members involved in allegations of abuse. • Safeguarding training and education have been delivered to both staff and management within the designated centre, reinforcing recognition, reporting, and prevention of abuse and ensuring clarity regarding roles and responsibilities. • To strengthen governance and clinical oversight, the Registered Provider has initiated recruitment to both Clinical Nurse Manager II (CNM II) posts within the designated centre. These roles will enhance supervision, monitoring, and support the delivery of safe and effective health and social care to residents. • A person centred approach to care has been enhanced across the designated centre. Staff have completed training in person centred care to ensure that residents' dignity, autonomy, rights, and individual preferences are central to care delivery. These measures collectively demonstrate improved safeguarding governance, effective risk management, and a strengthened commitment to protecting residents from abuse within the designated centre.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: ensure residents' rights are upheld and that care delivery aligns with a person centred, social model of care within the designated centre. Mealtimes, Choice and Environment • Person centred training has commenced within the designated centre to reinforce staff focus on residents' choice, will, and preferences, particularly in relation to mealtimes. • Residents are actively supported and encouraged, in line with their preferences, to utilise communal dining and canteen facilities, with mealtime arrangements facilitated as a matter of resident choice.	

- Awareness of noise levels during lunchtime meals has been raised with care staff, cleaning staff, and catering staff. Following consultation and discussion with all team members, practice changes have been implemented to reduce environmental noise.
- Signage is displayed during mealtimes to alert staff that meals are underway, supporting a calm and respectful dining experience.
- Call bell noise levels have been addressed and reduced to further enhance the mealtime environment.
- Nursing management provides active supervision and monitoring during lunchtime meals to ensure these practice changes are embedded and maintained.
- Menus have been created for the residents showing the meal options available to them and to allow residents to explore options in advance of ordering their preferred choice.

Language, Respect and Culture of Care

- Through education and daily reinforcement, staff are consistently encouraged to use respectful, person first language, including clearly referencing “residents” in all communications.
- Nursing management reinforces this practice through daily safety pauses and ongoing ward level supervision and monitoring to ensure compliance is embedded.
- Residents are to be invited to attend appropriate training sessions to increase awareness and participate in sessions i.e. fire Training

Choice, Movement and Use of Communal Space

- All residents are facilitated and supported each day to access communal areas, in line with their individual preferences, wishes, and assessed abilities.
- Where residents choose to spend time in their bedrooms, this preference is documented in their care plan and respected.
- Staff continue to provide encouragement and facilitation for residents to use communal areas while respecting individual choice and autonomy.
- Additional night duty staff have been implemented to further support residents’ choice and ability to access communal areas during evening hours.

Privacy and Visiting

- The visitor room in Ionad Eibhlis has been reinstated, ensuring residents in shared accommodation have access to a private space, located close to their living area, to receive visitors.
- All items previously stored in this room have been relocated to an appropriate alternative location, restoring the room to its intended purpose.

Activation and Meaningful Engagement

- A review of the activities programme within the centre has been completed.
- New weekly activities, including music therapy and chair yoga, have been introduced.
- A meaningful engagement Committee has been established to champion the ethos of the social care model.
- An enhanced activities schedule has been developed and implemented in consultation and collaboration with residents, ensuring activities reflect their interests and preferences.
- An activities satisfaction survey has been developed to capture residents’ preferences and feedback. This survey will be repeated at regular intervals to ensure ongoing responsiveness to residents’ wishes.

- A staff member assigned to activities is currently undertaking SONAS training to further enhance sensory based activity provision.
- A business case developed by the Person in Charge to increase Activities Coordinator provision has been approved, strengthening the centre's capacity to deliver meaningful activity.
- This enhancement is supported by person centred training, ensuring a whole centre approach to engagement, activation, and residents' quality of life.

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.	Substantially Compliant	Yellow	30/08/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	01/06/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	02/04/2026
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and	Substantially Compliant	Yellow	23/04/2026

	needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	28/04/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/07/2026
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	31/07/2026
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	Not Compliant	Orange	24/04/2026

	the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Not Compliant	Orange	13/04/2026
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.	Not Compliant	Orange	30/04/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested	Not Compliant	Orange	30/04/2026

	and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	24/04/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	01/06/2026
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	Not Compliant	Orange	08/06/2026

	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.	Not Compliant	Orange	08/06/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	01/06/2026
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	02/04/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	08/06/2026
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	31/08/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident	Not Compliant	Orange	08/06/2026

	may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	08/04/2026
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	08/06/2026