

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

Issued by the Chief Inspector

Name of designated centre:	St. John's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Ballytivnan, Sligo
Type of inspection:	Unannounced
Date of inspection:	05 June 2026
Centre ID:	OSV-0000660
Fieldwork ID:	MON-0050088

About the designated centre

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

The aim of St.John's Community Hospital is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being. The objectives of St. John's Community Hospital include providing a high standard of care in accordance with evidence based practice, providing individualised care to residents and their families respecting the choices, values, dignity and beliefs and ensuring that the residents live in a comfortable, clean and safe environment. St. John's provides a multi-disciplinary approach to the care of residents. The services provided include on-going care of dependant older people, palliative care, dementia care, and physical and mental health care. The centre comprises of four units, Tir na nÓg, Rosses, Cairde and Hazelwood unit. St. John's accommodates male and female residents over the age of 18.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	84
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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
Friday 5 June 2026	08:45hrs to 16:45hrs	Michael Dunne	Lead
Friday 5 June 2026	08:45hrs to 16:45hrs	Fiona Cawley	Support

What residents told us and what inspectors observed

Residents living in this centre were supported to enjoy a good quality of life. The inspectors found that the residents were content living in the designated centre and comfortable in the company of staff, who were observed to be attentive to residents' needs for assistance and support. Staff interactions with residents were observed to be caring, gentle and respectful throughout the day of this inspection. The inspectors' reviewed feedback from resident questionnaires on the quality of the service provided, and found that all responses were positive, with residents indicating that this was a great place to live.

Accommodation is provided across four units in a mixture of single and shared rooms, with Rosses unit designated for residents under 65 years of age, while Tir na Nog focused on residents with a formal diagnosis of dementia. The remaining two units, Cairde, and Hazlewood provide care and support for residents with varying dependencies and medical conditions. Each unit was self-contained with its own separate dining, visiting, and sitting room facilities. In addition, each unit had its own separate staffing arrangements in place.

Shortly after arrival at the designated centre, the inspectors were met by the person in charge, and following a request for documentation to support the inspection process, the inspectors commenced a walk around of all of the units where they had the opportunity to meet and chat with residents and staff members. Following the walk through the centre, the inspectors held an introductory meeting with the person in charge, and the assistant director of nursing (ADON), which included a review of the provider's compliance plan arising from the previous inspection held in July 2025. Inspectors also provided feedback on their observations and findings from the walk around the designated centre.

The inspectors observed that residents were well-dressed, and were found to be wearing well-fitting clothes and footwear. Residents were observed being supported by staff to attend to their personal care requirements. These tasks were carried out in a friendly, unhurried manner. It was obvious that staff were aware of residents' needs, and that residents felt safe and secure in their presence. Residents who requested support were observed to be provided with timely responses from the staff team.

Overall, the centre was clean and maintained for the comfort of the residents. There was a homely feel to the centre, and care was taken to decorate communal spaces with ornaments and comfortable seating. On the dementia unit, the provider had created a village-type mural scene displaying shop fronts that residents would have been familiar with in earlier times. Inspectors noted that new flooring was in place along the main corridor linking all of the units, while murals decorated the walls at the end of the corridor. The coffee shop was open from 10.30am to 12.30pm, and from 2pm to 4pm five days a week. This facility was observed to be popular with

residents, and their visitors and provided an alternative meeting point outside of the individual units. The provider was working towards providing this resource seven days a week.

Inspectors found some inappropriate storage of transfer and mobility equipment located in a resident room, a toilet, and in bathroom facilities. In addition, the provider had cordoned off an area of a residents' sitting room to store mobility equipment, and this had impacted on residents' enjoyment of their lived environment. This is discussed in more detail under Regulation 23: Governance and management.

Residents had access to several well-maintained gardens, which were suitable for the needs of the residents, although access from one sitting room was found to be impeded. These areas were adorned with flowers, shrubs and raised flower beds. A range of garden furniture and seating was available for the residents who frequented these areas. Residents were observed to be able to move about the centre and access all areas of their units. There were, however examples of resident mobility equipment stored in communal rooms, which had the potential to restrict residents' access to these facilities in their home.

The inspectors observed that resident bedrooms were personalised with belongings such as photographs, artwork, soft fabric blankets, books, and a selection of ornaments. Residents' bedrooms layouts provided sufficient space to meet residents' needs, including adequate wardrobe, and storage space for their clothes and personal belongings. Residents had access to television and call-bells in their bedrooms.

Information on planned activities and events was displayed across all units in the designated centre. The activity schedule was divided into morning and afternoon sessions. However, no scheduled activities were identified for the morning period in the Tir na nÓg unit. Inspectors noted that both the music and exercise sessions were scheduled for the afternoon.

During the afternoon, inspectors observed a music session in the garden room that was well attended by residents from all units. The session was engaging, and residents actively participated.

Many residents under 65 years of age were supported to access local amenities and facilities in Sligo Town. The provider also ensured that residents maintained strong links with the local community through a range of events organised within the centre. These included music and dance performances, which were enjoyed by residents, and contributed to opportunities for social engagement and community participation.

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

The overall findings of the inspection were that, for the most part, there were effective governance and management systems in place to ensure that residents were supported to have a good quality of life. The provider had addressed non-compliant findings that were identified on the previous inspection in relation to infection control. While efforts to achieve compliance in relation to Regulation 17: Premises and Regulation 21: Records were carried out, there were additional issues found on this inspection with regard to those regulations and these issues are discussed further in this report under the relevant regulations. While good levels of compliance were identified on this inspection overall, inspectors found that the measures in place in respect of residents' rights, records management, medicines management, and premises were not in full compliance with the regulations.

This was an unannounced monitoring inspection, conducted by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended).

The Health Service Executive (HSE) is the registered provider for this designated centre. There is a clearly defined management structure in place that is accountable for the delivery of safe and effective health and social care support to residents. The management team consists of a regional manager, who supports the person in charge with the day-to-day running of the centre. The clinical team also consists of a director of nursing, two assistant directors of nursing (ADON), and clinical nurse managers. A team of nurses, health care assistants, household, catering, maintenance, physiotherapy and occupational therapy support were also involved in the delivery of care to the residents in the designated centre.

The person in charge facilitated this inspection. They demonstrated a good understanding of their role and responsibility, and were a visible presence in the centre. There were deputising arrangements in place for when the person in charge was absent. Management support was also provided by the service manager for Older Person Services. Within the centre, lines of accountability and responsibility were clearly defined.

The provider was found to have made a change to the layout of the designated centre without informing the Chief Inspector of Social Services, and are therefore in breach of condition 1 of the Regulations. The registered provider was found to have erected a storage structure in a residents' sitting room. While it is acknowledged that the provider was attempting to improve storage facilities in the centre, the current arrangements meant that residents did not have full access to one of their sitting rooms. The provider re-instated this room to its original function the day after the inspection.

The inspectors found that, overall, there were sufficient resources in place in the centre to meet the assessed health care needs of residents. However, a review of the staffing rosters found that the allocation of staff to provide social care to residents was not adequate on the day of the inspection. While there was a range of activities available in the afternoon and facilitated by the care team, in contrast the availability of ongoing social care support prior to lunch was limited. This meant that residents did not have full access to a planned activities programme throughout the day.

The provider had a number of management systems in place to monitor the quality of the service in place. There was a schedule of audits, which reviewed areas of the service such as care planning, safeguarding, medicines management, nutrition, environment, and falls prevention. However, completed audits of various aspects of the service did not identify some issues found by inspectors on the day of the inspection, and as a result, there were no mitigations in place to address these issues.

The provider had systems in place to ensure that records were available and accessible, in line with the requirements of the regulations. However, some residents' records were not consistently stored securely in the centre, and had the potential to compromise resident confidentiality. This was brought to the attention of the provider, who addressed this on the day.

Staff had access to education and training appropriate to their role. This included fire safety, manual handling, safeguarding, managing behaviour that is challenging, and infection prevention and control training. Staff were observed to be competent in their individual roles, and said that they felt that the training received assisted them in their day-to-day role in caring for the residents.

An annual review of the quality and safety of the services had been completed for 2025, which included a quality improvement plan for 2026.

The centre maintained a risk register, which identified clinical and environmental risks in the centre, and the risk control measures in place to mitigate those risks. Arrangements for the identification and recording of incidents were in place, and well-managed by the provider.

A complaints policy and procedure, which clearly outlined the process of raising a complaint or a concern was available. Information regarding the process was clearly displayed in the centre. A review of the complaints log found that complaints were recorded, acknowledged, investigated, and the outcome communicated to the complainant.

Regulation 14: Persons in charge

The person in charge was a registered nurse with the required experience in the care of older persons and worked full-time in the centre. They were suitably

qualified, and experienced for the role. They had the overall clinical oversight for the delivery of health and social care to the residents and displayed good knowledge of the residents and their needs.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill-mix to meet the assessed needs of the residents in the designated centre. A review of the rosters confirmed that staff numbers were consistent with those set out in the centre's statement of purpose. The allocation of staff is discussed in more detail under regulation 23: Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a comprehensive training programme, which included induction training and ongoing mandatory training. A review of the centre's training matrix indicated that staff had received training in line with the designated centres training policy. As a result, staff were clear about what was expected of them in their work and demonstrated safe practices.

Judgment: Compliant

Regulation 21: Records

Records management was not in line with the requirements of the regulations. Inspectors observed a number of files that contained residents' personal details that were not stored securely. These records were stored near a nursing station on two of the units inspected.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided; however, some actions were required to ensure that these systems were sufficient to ensure the services provided are safe, appropriate and consistent. For example:

- The allocation of staff to provide social care support to residents throughout the day was not sufficient.
- The security arrangements in place to maintain confidentiality of resident records were inconsistent.
- Routine audits of the environment did not identify risks associated with ineffective guttering.
- Actions to address the lack of internal storage were ineffective.

The provider was in breach of Condition 1 of the registration as they had altered the layout of the centre without informing the Chief inspector of social services beforehand, through the submission of an application to vary this condition.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose which described the facilities and services available in the designated centre. This document contained all the required information as set out under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Reports of incidents which were required to be notified to the office of the Chief Inspector of Social Services had been submitted in line with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy in place which had been updated in line with regulatory requirements. Records of complaints were maintained in the centre, and the inspectors observed that these were acknowledged and investigated promptly, and the complainant's satisfaction was documented.

Judgment: Compliant

Quality and safety

Residents were supported and encouraged to have a good quality of life that was respectful of their choices and wishes. The inspectors found that care was delivered to a high standard, which on balance met residents' assessed health and social care needs. However, the availability of social care support, particularly in the morning time was limited.

A number of actions had been carried out by the provider to improve compliance with the regulations, and the inspectors observed that compliance plans from the last inspection had been implemented; however, more focus was required to achieve compliance under regulations related to residents' rights, medicines, and care planning. The inspectors found that there were areas related to the premises that required action, such as the wear and tear of existing guttering.

Care plans were developed in collaboration with residents or their representatives should residents be unable to actively participate. These care plans were well-written, providing clear instructions on the interventions necessary to meet the residents' assessed needs. Care plans were updated every four months or more frequently if needed. A small number of care plans had not been updated to reflect current interventions, and this meant that residents' care needs may not be accurately addressed.

Residents had regular access to medical and specialised treatments that met their needs. General practitioners (GPs) visited the centre every week or more frequently if needed. In addition, out-of-hours medical support was also available. Additional health care support was accessible through referral, and this included physiotherapy, occupational therapy, dietetic services, chiropody, and optician services.

There was a policy and procedure in place to guide staff on safeguarding vulnerable residents from abuse, and staff spoken with were clear on the procedure to be followed to protect residents from abuse and on how to manage any allegations of abuse. The inspectors reviewed a number of records which confirmed that there were measures in place to safeguard residents, and protect them from abuse. Residents stated that they felt safe living in the centre.

There was a restrictive practice policy in place to guide staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Records showed that when restrictive practices were implemented, a risk assessment was completed, and there was a plan in place to

guide staff. Alternatives to restrictive practices were trialled. There was a restrictive practice register in place, which was kept under review by the clinical team.

Staff who spoke with inspectors had up-to-date knowledge appropriate to their roles to positively react to responsive behaviours. Staff were knowledgeable on the triggers that may cause residents distress or anxiety, and were able to use de-escalation techniques to protect residents from harm. Referrals were made to specialist services for advice, as and when required. However, inspectors found that doors leading to an enclosed garden facility were locked, which impeded residents' free movement around their home. This was pointed out to the provider, who addressed this issue at the time.

There was evidence that residents were consulted about the quality of the service provided. Resident forums (meetings) were held every two months, and it was clear that the provider was using these forums to identify where improvements were needed by incorporating resident feedback into their action plans. There were no restrictions on visiting, with visitors observed attending the centre throughout the day. Residents had access to advocacy and to the centre's complaints policy.

There was an activity schedule advertised in all of the units inspected. Inspectors observed that while residents were provided with social care support, it was unsustainable for healthcare assistants to be allocated to provide a meaningful activity programme while at the same time providing personal care support to the residents.

Regulation 11: Visits

There were appropriate arrangements in place to ensure residents could meet with their visitors as they wished. Visitors were observed coming and going throughout the day, and told the inspectors that they could visit at times to suit them and the resident. There was a sign-in log which ensured that staff were aware of who was in the building. Visitors were seen meeting with residents in private areas located around the entrance lounge, as well as with the residents in their bedrooms.

Judgment: Compliant

Regulation 17: Premises

The provider had not ensured that all parts of the premises were appropriate to the number and needs of residents in accordance with the centre's statement of purpose. For example:

- The guttering was damaged in two areas of the centre, which caused water to leak onto the surface below, causing a slip hazard leading from the dining room to the garden area in Tir na Nog unit.
- There was inappropriate storage of three wheelchairs in a toilet facility located on Cairde unit.
- A full hoist was stored near a residents' bed, and encroached on the resident's ability to access this space safely.
- A section of a residents' sitting room was used as an equipment store.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy and procedure in place which contained details regarding the identification of risk, the assessment of risk and the measures and controls in place to mitigate against known risks. The policy met all the requirements as set out under Schedule 5 of the regulations.

Judgment: Compliant

Regulation 27: Infection control

The registered provider ensured that procedures, consistent with the standards for the prevention and control of healthcare-associated infections published by the Authority, were implemented by staff. Up-to-date training had been provided to all staff in infection control, hand hygiene and donning and doffing of personal protective equipment (PPE). Regular resident and staff meetings ensured that all were familiar and aware of the ongoing changes to guidance from public health and the HSE.

Regular audits of infection prevention and control, environment, and hand hygiene found good levels of compliance; the inspectors also noted that staff were seen to perform hand hygiene, and wear PPE at appropriate times while caring for residents.

The centre was clean and well-maintained. Effective cleaning processes were in place to support and maintain high levels of cleanliness.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that medication practices were in line with the safe administration of medicines professional guidance, for example:

- Some multi-dose medicines did not have a date of opening marked on them. This meant that staff would not be aware of the date of opening, and when the medication would become out-of-date, or that it should be removed from use for return to pharmacy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While each residents' needs were regularly assessed, actions continued to be necessary to ensure that residents' care plans were up-to-date, and that the care interventions that staff must complete to meet residents' assessed needs were clearly described. This was evidenced by the following findings;

- A care plan had not been developed to identify the interventions required to support a resident prior to a home visit.
- A social care plan had not been updated to reflect changes made to current interventions. This meant that care staff may not be able to provide the appropriate support required.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

A positive and supportive approach was used by staff in their care of a small number of residents who intermittently experienced episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were observed to be attentive to residents' individual needs for support, and residents responded well to the care and supports provided by staff. All staff were facilitated to attend appropriate training to ensure they had up-to-date knowledge and skills to effectively care for residents with responsive behaviours.

The person in charge and staff were committed to minimal restraint use in the centre, and their practices reflected the national restraint policy guidelines. There was minimal use of restrictive equipment, and alternatives to this restrictive equipment were risk assessed and used in consultation with individual residents and their representatives.

Judgment: Compliant

Regulation 8: Protection

The inspectors were satisfied with the measures in place to safeguard residents and protect them from abuse. A safeguarding policy was maintained, which guided staff on the measures to take to ensure residents were protected from harm. Residents who required additional measures to ensure their safety and well-being had safeguarding care plans in place to protect them from harm. Where the person in charge became aware of concerns, they ensured that investigations were carried out within defined timescales, ensuring that resident safety was prioritised at all times.

Safeguarding training was up-to-date for staff. Residents stated that they felt safe in the centre, and that they could approach any staff member if they had a concern.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that the residents were provided with sufficient opportunities to exercise their choice and participate in activities in line with their interests and capabilities. For example:

- There were limited activities available for residents to engage in before lunch on all of the units inspected. Healthcare assistants were allocated to provide activities for the residents; however, they were busy providing personal care support to residents during this time, and were unable to provide a sustained programme of activities.
- Access to a garden area on one unit was restricted as both doors leading to this facility were locked, which did not support residents' rights to access garden facilities freely.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. John's Community Hospital OSV-0000660

Inspection ID: MON-0050088

Date of inspection: 05/06/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • The person in charge and person participating in management have completed a review of the storage of resident's confidential records within the centre on the 19/06/2026. • All records containing residents' personal information are maintained securely in locked cupboards and designated storage areas that are accessible only to authorized personnel. • Access control measures applied to prevent unauthorized access at all times. All staff within the centre are aware of GDPR and Data Protection guidelines to ensure that residents' records are not left exposed or unattended, thereby safeguarding confidentiality and ensuring compliance with data protection and privacy requirements.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The person in charge and person participating in management have completed a staffing review on the 15/06/2026. A business case for the recruitment of additional resources of 2.5 WTE staff (HCA) to support activities was submitted by the person in charge to senior manager for onward approval through the decision register. It is envisioned that the approval and recruitment will be completed by Q1 2027. • The person in charge and person participating in management have completed a review of the activity schedule within the centre, and the timings of activities provided in	

line with residents preferred timing of activity engagement on the 15/06/2026.

- The person in charge reviews the existing staffing resources to allocate staff for the provision of social care, ensuring resident's needs are met consistently throughout the day.
- The Person in Charge is liaising with the Sligo Volunteer Centre to recruit up to 5 additional volunteer befrienders to support activities within the units during morning and evening time to support residents with their social care and to encourage community integration. Additional volunteers are expected to commence on the 05/10/2026 when the Garda Vetting process is completed.
- The person in charge and person participating in management have completed a review of the storage of resident's confidential records within the centre on the 19/06/2026.
- All records containing residents' personal information are maintained securely in locked cupboards and designated storage areas that are accessible only to authorized personnel.
- Access control measures applied to prevent unauthorized access at all times. All staff within the centre are aware of GDPR and Data Protection guidelines to ensure that residents' records are not left exposed or unattended, thereby safeguarding confidentiality and ensuring compliance with data protection and privacy requirements.
- The person in charge overseen the repair to the guttering defect identified on the day of the inspection in Tir Na Nog unit on the 26/06/2026, ensuring the continued upkeep and safety of the premises.
- The person in charge and domestic supervisor have completed a review of the environmental audit on the 15/06/2026, to include assessments of both the internal and external areas of the premises to ensure ongoing maintenance of the building and its grounds. Any maintenance issues identified through the audit process are addressed in a timely manner by the domestic supervisor with the maintenance manager.
- The altered layout within the unit identified on the day of the inspection has been reverted to its original configuration reflects the Statement of Purpose. This corrective action was completed on 09/06/2026, following the inspection and subsequently confirmed with the Inspector via email.
- The person in charge and person participating in management have completed a review of internal storage facilities within the centre on 14/08/2026. A suitable internal location has been identified to facilitate the safe and secure storage of equipment closer to the two units (Cairde and Hazelwood) where storage was identified as an issue. This is expected to be completed by the 02/10/2026 .
- The external location closer to Cairde and Hazelwood will require assessment by the Estates team and inclusion in the Minor Capital funding programme to ensure the issue is fully addressed. The estimated timeframe for completion is six months, with a target date of 28/02/2027.

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises: • The person in charge overseen the repair to the guttering defect identified on the day of the inspection in Tir Na Nog unit on the 26/06/2026, ensuring the continued upkeep and safety of the premises. • The person in charge and domestic supervisor have completed a review of the environmental audit on the 15/06/2026, to include assessments of both the internal and external areas of the premises to ensure ongoing maintenance of the building and its grounds. Any maintenance issues identified through the audit process are addressed in a timely manner by the domestic supervisor with the maintenance manager. • The altered layout within the unit identified on the day of the inspection has been reverted to its original configuration reflects the Statement of Purpose. This corrective action was completed on 09/06/2026, following the inspection and subsequently confirmed with the Inspector via email. • The person in charge and person participating in management have completed a review of internal storage facilities within the centre on 14/08/2026. A suitable internal location has been identified to facilitate the safe and secure storage of equipment closer to the two units (Cairde and Hazelwood) where storage was identified as an issue. This is expected to be completed by the 02/10/2026. • The external location closer to Cairde and Hazelwood units will require assessment by the Estates team and inclusion in the Minor Capital funding programme to ensure the issue is fully addressed. The estimated timeframe for completion is six months, with a target date of 28/02/2027. • This will support the effective management of the environment and ensure that residents are able to use their living space safely, free from obstruction or unnecessary hazards.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • The person in charge has completed a review of the center's medication with limited post-opening shelf lives, including bottles, ointments, creams, eye drops, and other applicable medicinal products on 17/06/2026. Date-of-opening stickers have been made available to all units through the Pharmacy Department for use on medicines with limited post-opening shelf lives, including bottles, ointments, creams, eye drops, and other applicable medicinal products. • The person in charge and clinical nurse managers have reviewed the medication audits per unit on 17/06/2026 to monitor compliance with this requirement and identify any areas requiring improvement. • The person in charge is overseeing the implementation of daily checks by nursing staff	

regarding the date of opening to ensure it is recorded on relevant medicines daily and prior to administration, thereby ensuring the safe management and use of medications within the centre.

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 and practice development coordinator have completed a comprehensive review of residents' care plans on the 26/06/2026. This review has provided the person in charge with assurances that care plans accurately reflect residents' assessed needs and that documentation is maintained in line with best practice standards.
- The person in charge supported the practice development coordinator in the delivery of care planning and documentation sessions for staff across the units to further strengthen staff knowledge and promote safe, consistent practice. The sessions have focused on enhancing the quality-of-care planning, record-keeping, and person-centred documentation.
- The person in charge continues to oversee and evaluate the scheduled care plan audits, in accordance with the established audit schedule. In addition, the person in charge and/or delegate are completing weekly reviews of random sampled care plans, to provide ongoing assurance that documentation standards are maintained and that practice remains compliant with organisational and regulatory requirements. Areas identified for improvement are communicated with staff and addressed promptly through the centre's quality and governance processes.

Regulation 9: Residents' rights

Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

- The person in charge and person participating in management have completed a staffing review on the 15/06/2026. A business case for the recruitment of additional resources of 2.5 WTE staff (HCA) to support activities was submitted by the person in charge to senior manager for onward approval through the decision register. It is envisioned that the approval and recruitment will be completed by Q1 2027.
- The person in charge and person participating in management have completed a

review of the activity schedule within the Centre, and the timings of activities provided in line with residents preferred timing of activity engagement on the 15/06/2026.

- The person in charge reviews the existing staffing resources to allocate staff for the provision of social care, ensuring resident's needs are met consistently throughout the day.
- The Person in Charge is liaising with the Sligo Volunteer Centre to recruit up to 5 additional volunteer befrienders to support activities within the units during morning and evening time to support residents with their social care and to encourage community integration. Additional volunteers are expected to commence on the 05/10/2026 when the Garda Vetting process is completed.
- The person in charge completed a review of access to internal garden areas on the 17/06/2026.
- Residents have safe and unrestricted access to the internal gardens and courtyards from all units within the centre. Access to the outdoor areas can be easily managed and used safely by residents.
- The person in charge oversees that residents' individual safety needs are regularly assessed, and care plans are reviewed and updated accordingly to reflect any changes in assessed needs or levels of support required.
- The thrice daily quality and safety report highlights any resident health and safety concerns to the person in charge to allow for risk assessment and mitigation. The person in charge and/or delegate conducts daily health and safety walkabouts within the centre to ensure residents are not impeded in using their personal and communal spaces safely and comfortably, free from unnecessary obstacles or hazards.

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	28/02/2027
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	19/06/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/03/2027
Regulation 29(5)	The person in charge shall ensure that all	Substantially Compliant	Yellow	17/06/2026

	medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	26/06/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	30/03/2027