Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

# Issued by the Chief Inspector

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| Name of designated centre: | St. Patrick's Care Centre |
| Name of provider: | Cowper Care Centre DAC |
| Address of centre: | Dublin Street, Baldoyle, Dublin 13 |
| Type of inspection: | Unannounced |
| Date of inspection: | 29 October 2025 |
| Centre ID: | OSV-0000179 |
| Fieldwork ID: | MON-0048473 |

## About the designated centre

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

St Patrick's care centre is based in Baldoyle, Dublin 13  and provides accommodation for 78 residents. The centre provides care and support for both male and female residents, primarily for those aged over 65. The centre contains a dementia specific area which can accommodate 15 residents. The majority of the accommodation provided is in single en-suite bedrooms with one bedroom offered on a shared basis. There are a number of communal rooms available for residents to socialise and meet their relatives.  Residents also have access to secure garden areas.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 75 |

## 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 |
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| Wednesday 29 October 2025 | 07:30hrs to 16:30hrs | Laurena Guinan | Lead |
| Wednesday 29 October 2025 | 07:30hrs to 16:30hrs | Yvonne O'Loughlin | Support |

## What residents told us and what inspectors observed

Residents living in St Patrick's Care Centre told inspectors that they were happy there and felt cared for, and inspectors saw residents being treated with kindness and respect. The centre was spread over two floors, with each floor divided into three units, one of which was a dementia specific care unit. The inspectors arrived while the night shift workers were on duty and saw that staffing levels were in line with the roster. The centre was calm, with two or three residents in the sitting areas, while the other residents were still resting in bed.

There was an open sitting area on each floor, as well as smaller visiting rooms. All these were seen to be clean and tidy. The corridors were free of clutter and had hand rails so that residents could move safely throughout the building. One smaller visiting room was called the 'music room' and was tastefully furnished with music memorabilia. The larger sitting area on the ground floor opened onto two secure courtyards with pathways, seating and attractive planting which made them pleasant and safe areas for residents to spend time in. An appropriately equipped smoking area was in one of the courtyards.

A sluice room with a bedpan washer was available on each unit for the cleaning of urinals and bedpans. However, on the day of inspection, three bedpan washers were unavailable for staff to use. One was out-of-order, and access to two others was restricted because the door swipe mechanisms for those sluice rooms were not functioning properly. Inspectors observed that this had an impact on infection prevention and control measures in the centre as some of the urinals found in residents' bedrooms and sluice rooms were visibly dirty. This is discussed later in the report.

The dementia specific care unit was located on the ground floor and accessed by a keypad. The code to this area was displayed on a sticker above the keypad. This unit had a sitting area and visitors' room which were clean, bright and comfortably furnished. An activities staff member was seen engaging the residents in one-to-one and small group activities appropriate to their interests and abilities. A visitor to the unit told inspectors that staff allowed the residents to do things in their own time and showed great patience if a resident became restless.

Overall, the centre was seen to be clean and well-maintained, although inspectors noted that hand hygiene sinks were not easily accessible throughout the centre, and areas of the laundry room were not clean. This will be discussed later in the report.

The inspectors saw a number of residents' bedrooms and they were clean and tidy, with many personalised with residents' own belongings. Residents who were in bed or spending time in their rooms were seen to have a call-bell within reach. A recent test of the sink in one en-suite bathroom had recorded high levels of bacteria in the

water, but the sink was still in use by the resident. This will be discussed later in the report.

During the day, the inspectors saw many kind and respectful interactions. Staff were seen to knock before entering a resident's bedroom, and residents and staff engaged in social, friendly conversations. Residents told inspectors that the staff were very kind and approachable. Visitors were seen coming and going on the day of inspection, and they told the inspectors that they were always made to feel welcome. The activities staff led a group session of exercises in the morning, with one resident saying it was her favourite activity. Other residents told the inspectors that they enjoyed doing jigsaws and colouring.

The inspectors saw both breakfast and lunch being served and they were told by residents that the food was tasty and plentiful. Residents had a choice to dine in their rooms, with many opting for this at breakfast. At lunch, there were two sittings in the dining room on the ground floor, and staff were seen to assist residents in a respectful and appropriate manner.

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

## Capacity and capability

This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and to follow up on information received by the Chief Inspector. Inspectors also followed up on the compliance plan from the previous inspection, and statutory notifications submitted to the Chief Inspector since the last inspection in February 2025. Inspectors saw that the centre was well-maintained, with a friendly and calm atmosphere, but the oversight and management systems in place were not sufficiently robust to assure that the service provided was effectively monitored, particularly in relation to Regulation 23: Governance and management and Regulation 27: Infection control.

The findings of the inspection were that the provider did not comply with Regulation 27 and the *National Standards for Infection prevention and control in community services* (2018). Weaknesses were identified with the environment, and the governance of infection prevention and control. Details of issues identified are set out under Regulation 23: Governance and management and Regulation 27: Infection control.

Cowper Care Centre DAC is the registered provider for St Patrick's Care Centre and the provider manages two other designated centres for older people in the Leinster region, with their headquarters on the same campus as St Patrick's Care Centre. The

person in charge was a qualified nurse who worked full-time in the centre, and the clinical director and CEO were on-site at least once per week. The person in charge was supported in their role by a team of nurses, health care assistants, activities coordinators, household, catering and maintenance staff.

The centre had experienced a number of resignations during the year but had recruited staff to fill most of these positions. One of the staff who had resigned was a dementia specialist nurse, and the inspectors were told that there were no plans to recruit for this position. This meant that the centre would not be operating in line with the statement of purpose, where this position is included as part of the staffing complement. The person in charge was informed of this. On the day of inspection, a member of the kitchen staff was unexpectedly absent, and the person in charge had not been informed of the absence to seek cover for this position. A senior manager had allocated one of the housekeeping staff, who had commenced cleaning duties, to work between the kitchen and cleaning departments. This will be discussed under Regulation 23: Governance and management and Regulation 15: Staffing.

Staff told inspectors they felt supported in their roles, and a new staff member said they had engaged in a thorough training and induction period. The inspectors saw a comprehensive suite of training available to staff, with a high level of compliance. However, the absence of a trainer due to a staff resignation resulted in a number of staff not being updated on their training in behaviour management. The inspectors reviewed staff disciplinary records and found them to be incomplete. This will be discussed under Regulation 16: Training and staff development and Regulation 23: Governance and management.

The inspectors saw that regular management, staff and residents' meetings were held, which showed good communication between all who worked and lived in the centre. The meetings had action plans and a nominated person to address issues identified, and there was evidence that these issues were dealt with appropriately. The inspectors saw that staff advocated on behalf of residents and staff, and residents also raised concerns and requests at residents' meetings. For example, residents had said that the waiting times for lunch could be quite long and in response to this, staffing levels in the dining room had been increased so that residents were served promptly. Both residents and staff told inspectors that they felt comfortable approaching management with queries or concerns, and they felt they would be listened to.

There was an annual review for 2024 and this had a quality improvement plan, and was seen to have been developed in consultation with residents. The compliance plan from the previous inspection had been implemented with the exception of a commitment to conduct monthly premises inspections with the maintenance staff. Nonetheless, maintenance records showed that there were no issues outstanding, and that maintenance requests were attended to promptly. Maintenance issues seen on the day were being addressed. There was evidence that a new bedpan washer had been ordered, and the maintenance staff were working to repair the door swipe mechanism.

Medication management audits stated that medication errors were being recorded correctly, but inspectors found that medication was frequently given outside the recommended time frames, and this had not been identified as a medication error. Some of these errors were due to the allocation of nurses at night. This will be discussed under Regulation 23: Governance and management, Regulation 15: Staffing, and Regulation 29: Medicines and pharmaceutical services.

On review of staff disciplinary records, inspectors saw two incidents that had not been identified as safeguarding concerns. While the person in charge had conducted investigations through staff disciplinary procedures, the records of these were incomplete, and the incidents had not been notified to the Office of the Chief Inspector. This will be discussed under Regulation 23: Governance and management and Regulation 31: Notification of incidents.

## Regulation 15: Staffing

The allocation of staff required review to ensure that absences were properly notified and dealt with, and to ensure the skill mix on each unit was appropriate to the needs of the residents. This was evidenced by:

- A housekeeping staff member was carrying out both kitchen and housekeeping duties due to an unplanned staff shortage. This had not been alerted to the person in charge and did not align with good infection prevention and control practices.
- The allocation of nurses at night meant that nurses on day duty were administering night-time medication, resulting in medication being administered outside the recommended time frames.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

The person in charge had not ensured that staff had access to appropriate training. Due to the resignation of the staff member responsible for providing the training, inspectors noted a reduced compliance in the number of staff who had completed training in behaviour management since June 2025.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The inspectors found that the management and quality assurance systems in place to ensure that the service delivered to residents was safe and effectively monitored remained inadequate in a number of areas, and consequently, most of the inspectors' findings on this inspection had not been identified by the provider through their own oversight and auditing processes. For example:

- The provider had received a report in September 2025 highlighting two water outlets with high counts of *Legionella* bacteria in the water supply. The water had been retested recently. As this issue had been ongoing since April 2025, the flushing regime had been increased, however, there were no records available to confirm this. On the day of inspection, an immediate action was given by the inspectors to close one of the en-suite sinks until the provider was assured that there was no further risk to the resident. There was no up-to-date risk assessment for management to review that the controls necessary to manage the risk were in place and reviewed.
- An out-of order bedpan washer was not labelled to indicate that it was out of use, and two other sluice rooms could not be accessed due to an issue with the door mechanism. Some of the staff working in the centre on the day of the inspection were unaware of this issue. An immediate action was given by the inspectors to place an out of order sign on the machine.
- Medications given outside the prescribed time were not identified by management and staff as a medication error and as a result they were not addressed in a timely manner.
- Records for staff on disciplinary procedures were incomplete. For example, a staff member had been on a performance improvement plan, but there was no record that the effectiveness of the plan had been assessed after the decided completion date had passed. The person in charge told the inspectors that an informal meeting had been held and the staff was deemed to have completed the plan satisfactorily. This posed a risk that poor performance was not being addressed appropriately and in line with the providers policy.
- Management and oversight systems had not ensured that incidents were correctly identified, and reported to the Chief Inspector within the required time frames. This was a repeat finding.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Two incidents had not been identified as safeguarding concerns, and had not been notified to the Office of the Chief Inspector. This was a repeat finding. One notification was received 13 days later than the required time frame.

Judgment: Not compliant

## Quality and safety

Residents living in St Patrick's Care Centre were seen to receive a good standard of care from staff who were familiar with their needs and preferences. However, improvements were required in the administration and disposal of medicines, infection prevention and control (IPC), and the management team's knowledge of residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

The inspectors reviewed six residents' care plans and saw that residents were assessed using validated assessment tools, and care plans were developed within 48 hours of admission. The care plans were person specific, and directed care in line with the assessments. Residents were seen to have been reassessed on a regular basis, and care plans were reviewed on a four monthly basis, or more regularly if required.

Residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were seen to have care plans in place to inform staff of potential triggers, and recommended de-escalation techniques to use. The registered provider had ensured a restraint register was available, and restraint was used in accordance with national policy. Inspectors saw that restraint assessments and consent were in place for residents who required measures such as bed rails or alarm mats. Recommended safety checks were seen to be carried out in a timely manner. Staff involved in direct resident care displayed a good knowledge of residents' behaviours and how to manage them appropriately. Staff working in the dementia unit told inspectors that they relied on staff from other units on a daily basis to assist when residents became distressed. This had been reported to management. However, when asked by inspectors at the introductory meeting, management were not aware of all residents who displayed responsive behaviours. This will be discussed under Regulation 7: Managing behaviour that is challenging.

A quality improvement board near reception showed that antibiotic usage was monitored and trended. There was a low level of prophylactic antibiotics used which was good practice. However, areas of improvement in IPC were identified and are discussed under Regulation 27: Infection control.

The centre had a clinical room on the ground floor where medicines and medication trolleys were stored. This was accessed by a swipe card lock. All presses and the medication fridge were locked, and the keys were held by the nurse on duty. The trolleys were kept locked and chained to the wall in the clinical room when not in use. On the morning of the inspection, two of the trolleys were left unattended beside the first floor sitting area where two residents were sitting, with a key in each one. This was brought to the attention of the assistant director of nursing, who removed the keys immediately and returned them to the nurse on duty. Later in the

day, the swipe card system was undergoing maintenance and the clinical room was therefore unlocked. Medication to be returned to the pharmacy was in an open box on the counter. The person in charge was informed and the medication was removed to a secure location. The registered provider had secured the services of a local pharmacy and staff reported that delivery was prompt and regular. The centre held an emergency stock of certain medications, but the inspectors found antibiotics that had been prescribed for residents and were no longer needed were being held as emergency stock. This was not in accordance with national legislation on the disposal of medication and will be discussed under Regulation 29: Medicines and pharmaceutical services. This was discussed with the clinical nurse manager who removed medications prescribed for residents from the emergency stock supply. Additionally, there was no schedule to check the amount and expiry date of the emergency stock. Records showed that weeks or months elapsed between stock checks for individual medications. This was also brought to the attention of the clinical nurse manager.

## Regulation 27: Infection control

The registered provider had not ensured that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority were implemented by staff. For example:

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- Urinals in some residents' rooms had not been processed in a bedpan washer and were visibly stained. In addition, two sluice rooms contained heavily stained urinals stored on the clean rack, indicating that contaminated equipment may not have been cleaned properly.
- There were no hand hygiene sinks that were easily accessible for staff to wash their hands if they were visibly soiled. This posed a risk to the increase of cross-contamination and transmission of infection.
- One resident's en-suite sink had high counts of *Legionella* bacteria in the water supply and was not taken out of use. This increased the risk of a resident developing a healthcare-associated infection.
- Sharps management needed to improve. For example, the provider had not introduced needles with a safety device in line with evidence-based guidelines. This increased the risk of staff sustaining a sharps related injury. The sharps box in use was open and not signed or dated to give traceability of origin.
- A section of the laundry room was visibly dirty, with used linen on the floor.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

The person in charge had not ensured the secure storage of medicines. This was evidenced by:

- Medicine trolleys were left unattended with keys in the lock.
- Medicines were found in an open box while the clinical room was unlocked.
- The emergency medicines stock was not checked on a regular basis, which posed a risk of medicines passing their expiry date, and overstock of medications.

The person in charge had not ensured that medicines no longer in use were disposed of in accordance with national legislation on the disposal of medication.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

Residents were assessed, and care plans developed within 48 hours of admission. Care plans were seen to be reviewed on a four monthly basis, or more frequently if needed.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

The person in charge had not ensured that staff had up to date knowledge of residents who displayed responsive behaviours. This was evidenced by:

- Nursing staff informed inspectors of residents who displayed responsive behaviours, and inspectors reviewed records of incidents that had occurred in recent weeks. However, during the introductory meeting, members of the management team did not disclose these incidents. In addition, staff on one unit reported that they frequently required assistance from another unit to help them manage residents' responsive behaviours.
- 14% of staff had not updated their training in responsive behaviour management.

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 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 27: Infection control | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 5: Individual assessment and care plan | Compliant |
| Regulation 7: Managing behaviour that is challenging | Substantially compliant |

# Compliance Plan for St. Patrick's Care Centre OSV-0000179

## Inspection ID: MON-0048473

## Date of inspection: 29/10/2025

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 15: Staffing:
Overview
The removal of the Dementia Clinical Nurse Specialist (CNS) role from the Statement of Purpose was implemented following a careful and considered review. In order to maintain consistency of care, strengthen governance, and ensure an effective management structure within the Dementia Unit, the following measures have been introduced.
Measures Implemented
- The organisation currently has two Dementia Capable Care (DCC) trainers who share responsibility for delivering both initial and refresher DCC training. All staff members now hold current DCC certification.
- The local system for monitoring and managing staff training has been reviewed and updated, ensuring regulatory compliance and accountability.

Revised Training Oversight Process
1. The Clinical Nurse Manager (CNM) will review staff training status on a monthly basis.
2. Refresher training will be scheduled one month prior to expiry. Training dates will be integrated into staff rosters and displayed on staff noticeboards.
3. Staff members with expired training will be removed from the roster until compliance is re-established.
4. The Care Manager/Person in Charge (CM/PIC) will provide oversight and incorporate training compliance data into the monthly operational report.

Management of Challenging Behaviour
- The Dementia Link Nurse and the Healthcare Assistant (HCA) Team Leader maintain an active presence within the unit.
- The CM/PIC, a qualified Safeguarding Trainer, provides support and guidance. In their absence, the Assistant Care Manager (ACM) and CNM are available to manage complex behavioural concerns.
- Coordination with the Community Old Age Psychiatry (OAP) and Gerontology Teams is led by the ACM, who possesses extensive clinical expertise.
- Care plan formulation and review are conducted by the Dementia Link Nurse,

supported by the HCA Team Leader and supervised by the CNM.

- De-escalation strategies are developed collaboratively with the CM/PIC, ensuring the safety of residents and staff.
- Oversight of dementia-related policies and procedures remains the responsibility of the Head of Services – Care.

Staffing Allocation

The former Dementia CNS was employed on a 0.5 Whole Time Equivalent (WTE) basis as CNS and 0.5 WTE as staff nurse. The staff nurse hours have been fully replaced to ensure compliance with staffing requirements and to maintain care continuity.

The shift of nurses in dementia unit has been reviewed to accommodate medication administration times to be in line with prescribed timeframes. The day shift will now be 9am – 9pm and the night shift will be 9 pm – 9 am.

All managers both clinical and non-clinical in St. Patricks Care Centre have been instructed to ensure that all absences and re-allocations/skill mix of staff are communicated and approved by the Care Manger/PIC first before implementation.

No staff member will be allocated to work between the communal areas and kitchen at the same time in line with best practice in IPC. In cases of unplanned staff shortages for all departments, Cowper Care will utilise Agency staff or co-ordinate with the sister nursing homes to cover critical shortage as approved by CEO.

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| Regulation 16: Training and staff development | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Overview

The CM/PIC is responsible for ensuring that mandatory staff training is completed in accordance with the required schedule. The following procedures are in place to maintain compliance and efficiency.

Procedures

- Training is scheduled one month prior to expiry, with the CNM managing the central training matrix and notifying relevant staff.
- The CNM, supported by the CM/PIC, ensures all employees maintain full compliance.
- The Registered Provider guarantees the availability of qualified trainers for all mandatory training sessions.
- The CM/PIC ensures smooth coordination among all training stakeholders.
- Staff members are remunerated for their training attendance to promote full engagement and compliance.
- Should a trainer resign, the Provider will ensure a replacement is appointed before departure to prevent disruption. Within the Cowper Care Group, trainers from other

nursing homes may be allocated additional time to facilitate training sessions at St. Patrick's Care Centre.
Long-Term Training Development
• Cowper Care is committed to ongoing staff education to promote leadership development and succession planning.
• Compliance with mandatory training requirements remains a standing agenda item in the monthly operational meetings.
• Staff who are not compliant with training regulations will not be permitted to work until requirements are fulfilled.

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| Regulation 23: Governance and management | Not Compliant |

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

Cowper Care will continue to ensure a safe supply of water to its facilities. Water testing is done every 6 months as coordinated by the Facilities Manager.

The Facilities Manager will continue to update the Care Manager/PIC and CEO regularly as issues arise; full updates are presented at the monthly Operational meetings. Any urgent issues which could affect the safety of residents, staff, and visitors will be addressed promptly.

Following identification of any concerns, the Care Manager/PIC will ensure a risk assessment is carried out immediately and ensure the local risk register is updated to inform and guide staff. The Care Manager/PIC has oversight of the local risk registers. The Head of Services – Care/clinical director has overall oversight of corporate risk registers at Cowper Care Centre DAC to ensure full compliance.

The out-of-order bedpan washer without signage – the facilities department and all other staff members have been reminded of their responsibility to ensure all equipment out of order is clearly labelled and repaired or replaced at earliest convenience and all staff will be made aware by the Care Manager/PIC. The reporting of faulty equipment will continue to be through our e-system for effective management and compliance purposes; the Care Manager/PIC has oversight to check every morning or when an issue is logged.

Incomplete Disciplinary Procedures – The Care Manager/PIC will ensure all Performance Improvement Plans are followed through, monitored and assessed with agreed time frames. Consequences will be addressed and clearly indicated during review meetings. This is already in place.

Notification of incidents – The Care Manager/PIC will ensure that any senior manager who will be deputize in his absence is well informed on identification and reporting of incidents to the Chief Inspector in a timely manner. The Care Manager/PIC remains the individual with oversight on reporting incidents in the care center. In the Care Manager/PIC's absence, the manager in charge will liaise with the Head of Services – Care/clinical director for clarification if in doubt.

| Regulation 31: Notification of incidents | Not Compliant |
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Notification of incidents – The Care Manager/PIC will ensure that any senior manager who will deputize in his absence is well informed on identification and reporting of incidents to the Chief Inspector in a timely manner. The Care Manager/PIC remains the individual with oversight on reporting incidents in the care center. In the Care Manager/PIC's absence, the manager in charge will liaise with the Head of Services – Care/clinical director for clarification if in doubt.

The Care Manager/PIC will liaise with the Case Holder Inspector if in doubt about any incident to avoid non-compliance with reporting of the same. The Care Manager/PIC will ensure noncompliance in incident reporting does not happen again.

| Regulation 27: Infection control | Not Compliant |
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Outline how you are going to come into compliance with Regulation 27: Infection control:
Stained Urinals – These were replaced immediately; the HCA Team Leaders will continue to check these every day during their rounds and ensure all clinical managers are well informed on compliance. All staff have been informed at handovers and staff meetings to focus on identifying unsuitable appliances and reporting to managers for repair or replacement without delay.

Clinical Hand-Washing Sinks –
The installation of new handwashing sinks is scheduled for completion by 30 June 2026.This project forms part of the ongoing infrastructure improvement plan aimed at enhancing infection prevention and control standards across the facility.

The presence of Legionella Bacteria - Cowper Care will continue to ensure safe supply of water to its facilities. Regular water testing remains in place and is done every 6 months. Compliance in environmental audits will be closely monitored by the Care Manager/PIC and the Facilities Manager. Non-compliances identified in each audit will be dealt with promptly.

The Facilities Manager will continue to update the Care Manager/PIC on the progress of action plans and provide an overall project update at the monthly Operational meetings. On identification of any urgent concerns, appropriate action will be taken promptly in consultation with the Care Manager/PIC and/or CEO.

The House Keeping Supervisor has been instructed to commence a check sheet for flushing of all water taps to prevent Legionella bacteria. The flushing will be done weekly. The Care Manager/PIC will continue to have an oversight to ensure compliance with the same.

Laundry facilities – The Housekeeping supervisor has been instructed to ensure laundry facilities are always clean and in compliance with IPC best practices. The Care Manager/PIC will check every day as part of his daily checks. The Care Manager or PIC/ACM will also do regular environmental walk abouts with the facilities and housekeeping staff at least once per month.

Sharps Management: The use of needles with a safety clip is now in place; the Care Manager/PIC will ensure the care center is in line with IPC best practice. This will be achieved by regular engagement with the pharmacy supplier and adapting best practice updates. The management of sharps and their disposal have been emphasized to all staff to comply with local policies and procedures, environmental health, and current IPC guidelines. Staff training in IPC, including the management of sharps, is part of the Induction training. Identified gaps in IPC practices are also discussed during regular clinical meetings and handovers.
The Care Manager/PIC will check compliance with the same daily during his usual rounds and will be responsible for auditing the same.

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| 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 nurses in Cowper Care are required to complete an online medication management training annually. Compliance is monitored by the Care Manager/PIC. Regular medication audits are also conducted by the link nurses. The Care Manager/PIC has oversight into medication management in the care center.

The Care Manager/PIC will ensure full compliance with the safety of medications management. Unsafe medication management practices will be addressed according to local policies and procedures.

The Care Manager/PIC will review and discuss the local policies and procedures in medication management and storage to all nurses at handovers and clinical meetings. Random spot checks will be carried out to ensure compliance.

The access keypad to the medications room malfunctioned on the day of inspection and has since been repaired, nonetheless all nurses were reminded to ensure safety of medications as mentioned above. Medications will be locked away in the press if the keypad stops working again.

Expiry dates and inventory checks of Emergency medications will be monitored by the Assistant Care Manager monthly. Inventory records will be kept for reference. Any leftovers from discontinued medication courses will be checked on a weekly basis and returned to the pharmacy for disposal. This routine will be added to the weekly checklist of nurses. Records of medication return will be kept for reference.

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| Regulation 7: Managing behaviour that is challenging | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

Staff Training

• All staff members working in the Dementia Unit must maintain current DCC training certification.
• The CM/PIC oversees all training related to responsive behaviour management, while the CNM ensures all staff remain compliant and scheduled appropriately.
• The previous 14% of staff with outstanding DCC training are now fully compliant.
• Staff are reminded that failure to attend scheduled training will result in removal from the roster until training is completed.

Management of Challenging and Responsive Behaviours

• The CM/PIC and Bed Manager work collaboratively to ensure that only appropriately assessed and suitable residents are admitted to the Dementia Unit.
• The CM/PIC ensures all staff are familiar with residents exhibiting challenging behaviours and trained in de-escalation techniques.
• Residents demonstrating responsive or disruptive behaviours are referred promptly to the Community OAP and Gerontology teams for assessment and intervention.
• The Dementia Link Nurse will be allocated one protected day per month to focus on unit-related matters, including record updates, family meetings, and issue resolution in collaboration with the ACM. An additional day will be dedicated to updating care plans.

These dedicated times are reflected in the staff roster.
• A core team of staff is being established within the Dementia Unit to promote continuity of care, improved resident understanding, and overall quality enhancement.
Governance and Oversight
Any incidents or patterns of serious challenging or responsive behaviours are discussed during operational meetings chaired by the Chief Executive Officer (CEO). Lessons learned and action points are documented and reviewed to ensure continuous improvement and regulatory compliance

## 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 | 31/01/2026 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training. | Substantially Compliant | Yellow | 31/12/2025 |
| Regulation 23(1)(d) | The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. | Not Compliant | Orange | 31/12/2025 |

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| Regulation 27(a) | The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff. | Not Compliant | Orange | 30/06/2026 |
| Regulation 29(4) | The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre. | Substantially Compliant | Yellow | 31/12/2025 |
| Regulation 29(5) | The person in charge shall ensure that all 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. | Substantially Compliant | Yellow | 16/12/2025 |
| Regulation 29(6) | The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by | Substantially Compliant | Yellow | 08/12/2025 |

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| | that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product. | | | |
| Regulation 31(1) | Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence. | Not Compliant | Orange | 08/12/2025 |
| Regulation 7(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging. | Substantially Compliant | Yellow | 31/12/2025 |