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

Name of designated centre:	Phoenix Park Community Nursing Units
Name of provider:	Health Service Executive
Address of centre:	St Mary's Hospital, Phoenix Park, Dublin 20
Type of inspection:	Unannounced
Date of inspection:	30 September 2025
Centre ID:	OSV-0000476
Fieldwork ID:	MON-0044993

About the designated centre

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

Phoenix Park Community Nursing Units can accommodate 146 residents, both male and female over the age of 18. The registered provider is the Health Service Executive and is located on the St. Mary's Hospital Campus, Phoenix Park in Dublin. The centre consists of two purpose-built buildings,Teach Iosa (100 beds) and Teach Cara (46 beds). Both buildings have two storeys, and are divided into six units. Residents of all levels of dependency can be accommodated in the centre, and 24 hours nursing care is provided. There are a range of multidisciplinary staff who strive to promote person centred care and aim to implement evidence based quality care for all residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	134

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 30 September 2025	07:30hrs to 16:30hrs	Sarah Armstrong	Lead
Tuesday 30 September 2025	07:30hrs to 16:30hrs	Niamh Moore	Support
Tuesday 30 September 2025	07:30hrs to 16:30hrs	Aoife Byrne	Support

What residents told us and what inspectors observed

In general, on the day of inspection, inspectors found that the majority of residents were positive about their experience living in Phoenix Park Community Nursing Units and said they were happy with the level of care and support provided. Residents spoken with stated "I feel more secure here than I would at home" and "I am very happy living here", while another was complimentary towards staff stating "staff are terrific". Overall, staff spoken with were knowledgeable of residents' needs and preferences, and there were many positive engagements observed between staff and residents on the day of the inspection. However, not all staff were aware of the residents' identified needs, resulting in inconsistent care and support practices.

Phoenix Park Community Nursing Units consists of two separate buildings referred to as Teach Iosa and Teach Cara. Inspectors arrived to the Teach Iosa building at 07:30am to introduce themselves and sign in. Following a brief discussion with the manager in charge, the inspectors completed a walk around of the premises commencing with the Teach Cara building. This building consisted of two residential units, for a maximum of 46 residents, referred to as Bebhinn and Setanta. The Bebhinn unit is located on the ground floor and contained 17 single bedrooms, two twin bedrooms and one four bedded-room. The Setanta unit is located on the first floor and contained 19 single bedrooms and one twin bedroom. The Teach Iosa building contains four residential units, for a maximum of 100 residents. Oisin and Conall units were located on the ground floor and Tara and Ailbhe units on the first floor. All four units contained 17 single bedrooms, two twin bedrooms and one four bedded-room.

Inspectors observed some common themes across all six units. For example, some communal areas such as a multi-purpose room and a designated smoking area in Teach Cara did not have a call bell should a resident need to call for assistance. The inspectors observed that the level of cleanliness throughout the centre was good. However, inspectors saw that there was inappropriate storage observed in assisted bathrooms and store rooms, such as manual handling equipment, bedpans and boxes of personal protective equipment (PPE) stored on the floor, preventing effective cleaning and infection control measures in these areas. Inspectors also observed a substantial amount of wasps in one unit, including in the residents' bedrooms and corridors. Inspectors were told by staff that the problem was persisiting for at least a month, and while they closed windows the wasps were still getting in. Inspectors found that the action taken to respond to this issue was insufficient.

In both buildings, residents were encouraged to decorate their bedrooms with personal belongings to create a more homely and familiar environment. However, inspectors found that some areas of the centre were in disrepair, including torn wallpaper and damaged flooring in Teach Cara, and armchairs with rips and tears were observed in both buildings. Furthermore, a number of doors were found to be

locked on the day of inspection which restricted residents' access to secure outdoor courtyards and balcony areas.

During the walk around, inspectors observed that one staff member allocated as a companion carer for one resident was also the only staff member present in a communal area accomodating up to 15 residents. Feedback from most residents was that staff are responsive to their needs. However, some residents said that they were occasionally left waiting for staff assistance, or that there were times when they experienced delays in their call bell being responded to as "staff can sometimes be busy".

On units where there was an outbreak of COVID-19, inspectors observed there was unclear signage regarding the outbreaks to inform visitors of the requirement to use personal protective equipment. Furthermore, a number of staff were not wearing face masks appropriately. For example, staff were observed pulling down their face mask when talking to residents and visitors, this is not in line with best practice and infection prevention and control guidance.

Overall the dining experience was observed to be a pleasant and enjoyable experience for most residents. However, not all staff were seen to take a person centred approach to the care they provided, inspectors observed on one unit staff standing over residents in an undignified manner when providing them with support and assistance during their meal.

There were information boards available on each unit. These boards provided useful information to residents including details on advocacy services, the Health Service Executive's complaints procedure referred to as 'your service your say' feedback process' leaflets, and the centre specific residents' guide. However, two residents spoken with told inspectors that they were not aware of the complaints procedures for the centre.

The next two sections of this report set out the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered to residents.

Capacity and capability

Overall, inspectors found that improvements were required in respect of the oversight and management processes in place to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored.

This was an unannounced inspection carried out by three inspectors of social services over the course of one day, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations

2013 (as amended). The inspectors also followed up the compliance plan received from the previous inspection carried out in October 2024, unsolicited information received and statutory notifications submitted by the provider since the last inspection.

Inspectors found that the registered provider had not actioned all aspects of the compliance plan committed to following the previous inspection. While some actions had been completed, including implementation of enhanced oversight of cleaning practices and measures to address fire safety concerns, several actions remained outstanding. These included the secure storage of residents files and the repair of damaged flooring in Teach Cara. These findings are further detailed under Regulation 21: Records and Regulation 17: Premises.

The registered provider of Phoenix Park Community Nursing Units is the Health Service Executive. There was a well defined management structure in place. The registered provider assured the inspectors that they were actively recruiting both staff nurses and health care assistants at the time of inspection and new staff had commenced employment in the weeks prior to the inspection.

Staff had access to a suite of training relevant to their role including infection control, manual handling and frailty. Areas for improvement in mandatory training are discussed under Regulation 16: Training and staff development. It was identified on the day of the inspection that 48% of staff had up-to-date training on managing behaviour that is challenging. This training provides staff the appropriate skills and knowledge for their role and how to manage 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 registered provider assured the inspectors that this training is now included in their mandatory training and is currently being rolled out to staff. This will be discussed further in the quality and safety section of this report and under Regulation 7: Managing behaviour that is challenging.

The registered provider had good oversight of incidents. A clinical review committee was established which met on a monthly basis to identify incidents that occurred in the centre and actions taken.

Regulation 15: Staffing

There were adequate numbers of staff on duty with appropriate skill-mix to meet the needs of the residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a comprehensive range of training that included both mandatory and supplementary training. However, a review of training records identified that not all staff had up to date training completed. For example;

- 20 staff had not completed refresher fire safety training
- 32 staff had not completed safeguarding vulnerable adults training

The registered provider had not ensured that staff were appropriately supervised. For example;

- Staff were observed using personal protective equipment incorrectly during an outbreak of COVID-19. Staff were observed removing their face masks when talking to residents and visitors. This practice does not ensure that residents, staff and visitors to the centre are protected from the risk of infection.
- Enhanced supervision of staff practices during mealtimes was required to ensure residents' dignity at mealtimes was upheld.

Judgment: Substantially compliant

Regulation 21: Records

The registered provider had not ensured that records were kept in line with the regulations. For example:

A repeat finding of the inspection in October 2024 was found where not all records were stored securely:

- In all but one unit, the filing cabinets that contained residents' files were unlocked.
- In one unit, residents' files were stored in storage boxes at the nurses' station.
- Information contained in handover documentation and team diaries were easily accessible in the nurses' stations which were unattended at times.

Inspectors found there were gaps in the completion of some records required under Schedule 3 of the regulations. For example, three residents who required safety checks as per their care plan documentation did not have these recorded on the day of the inspection.

Judgment: Not compliant

Regulation 22: Insurance

The registered provider had in place a contract of insurance against injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured that effective systems were in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example;

- Oversight systems had not identified that not all rooms were equipped with call bells, meaning residents were not always able to call for assistance if required in these areas. This is discussed further under Regulation 17: Premises.
- The registered provider had not appropriately addressed or managed the significant infestation of wasps along a bedroom corridor in the Setanta unit.

In addition, oversight of staff practices and management systems were not robust. This was evidenced by;

- Insufficient oversight of the implementation of the compliance plan from the previous inspection to ensure that residents' records were stored securely and sluice room doors were secured.
- Insufficient oversight of documentation to ensure that care plans and assessments were updated and accurate to enable staff to deliver care appropriately.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All incidents had been submitted within the correct time-frame as per the regulatory requirements.

Judgment: Compliant

Regulation 4: Written policies and procedures

All policies and procedures required under Schedule 5 were in place, and staff were knowledgeable of them. However, the centre's policy on risk management and safeguarding had not been reviewed and updated following the amendments to the regulations in March 2025.

Judgment: Substantially compliant

Quality and safety

Overall, residents living in Phoenix Park Community Nursing Units received a good standard of care. Residents had good access to health care professionals including medical practitioners, physiotherapist, occupational therapist and tissue viability nurse. Medical support was also available out of hours where required.

A sample of residents' records were reviewed on the day of inspection. An assessment was carried out prior to admission to the designated centre. Validated assessment tools supported the assessment of residents to establish if residents were at risk of malnutrition, falls or impaired skin integrity. Inspectors saw that overall, care plans were updated at four monthly intervals in line with the regulations. However, there were examples seen that care plans were not always developed based on assessed needs and some care plans did not have sufficient information to guide staff practice.

There was a policy on responsive behaviours available for staff. Inspectors saw evidence where residents who were predisposed to episodes of responsive behaviours had de-escalation measures trialled, however not all residents where required, had a responsive behaviour care plan developed to guide staff which is outlined under Regulation 5: Individual assessments and care plans. In addition, inspectors found the management plan for one resident was restrictive. This and other gaps are further discussed under Regulation 7: Managing behaviour that is challenging.

Staff spoken with were clear about their role in protecting residents from abuse, and the reporting structures for safeguarding. There was a safeguarding policy dated October 2024 which provided support and guidance in recognising and responding to allegations of abuse, however as outlined earlier in this report, this policy had not been updated following the changes to the regulations in March 2025. Safeguarding incidents were referred to the social work team which was also on site on the campus. Notwithstanding some of these good practices, improvement was required

in the safeguarding measures in the centre which is further discussed under Regulation 8: Protection.

Inspectors observed the lunchtime experience and residents had an option of cod or chicken on the day of inspection. Residents were provided with a weekly menu with the different options available for each meal. Inspectors observed that the same meal choices were available to all residents including those that required modified diets as per their assessed needs. The different food consistencies served to residents reflected their assessed needs. The food was presented neatly, as a result, the resident could identify the different food groups on their plate.

The inspectors observed safe and appropriate practices in the administration of medicines to residents, with medicines given as prescribed and dispensed. However, inspectors found that staff in two units were not familiar with the registered provider's process for return and disposal of medicines.

Improvements were required in respect of the premises to ensure compliance with the regulations. Inspectors identified areas used by residents which were not equipped with emergency call bell facilities. Furthermore, some areas were scuffed and some furniture was damaged or torn across both buildings. These findings are discussed further under Regulation 17: Premises.

Inspectors found that residents' did not have equal opportunities to participate in meaningful activities. While on the day of inspection, inspectors observed many residents engaging in interactive activities in communal spaces, including balloon games, bingo, music and proverbs, other residents were observed to be spending their day in their bedrooms. Inspectors spoke with some of these residents. Some told inspectors that they liked to keep to themselves, that they enjoyed their own company and staff respected their wishes. However, one resident who was observed to be sleeping in their bedroom for much of the day with little engagement from staff, told inspectors that they had "nothing to do", and did not know what types of activities were available or where they could find out this information. Findings in respect of residents rights are described under Regulation 9: Residents' rights.

Regulation 17: Premises

The premises did not conform to all matters set out in schedule 6 of the Regulations. For example;

- Emergency call bell facilities were not available in every room used by residents, including smoking areas and conservatories.
- There was inappropriate storage throughout the centre, for example, baths in assisted bathrooms were being used to store items including foot rests from wheelchairs and window blinds and bathrooms were found to be storing mobility equipment. There was also storage of boxes and other items on the floor in several areas throughout the centre, meaning these areas could not be effectively cleaned.

- A store room in Bebhinn had a light switch fixing removed from the wall and the wires were exposed.
- Residents' chairs were observed to have rips and tears in both buildings of the centre.
- The flooring in Teach Cara had not been repaired as per commitments of the compliance plan from the last inspection. This work remained outstanding.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

All residents had access to fresh drinking water, refreshments and snacks throughout the day. Residents had a choice of menu at meal times and adequate quantities of nutritious food. Residents' dietary needs were met.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Some medicine management systems required improvements. There was evidence that medicinal products were not stored safely and securely in the centre, for example;

- Inspectors observed the medicine trolley open with the key freely accessible in the lock stored in a locked clinical room.
- Medicinal products supplied for residents were not stored safely or in line with the product advice. Inspectors reviewed the temperature records for the clinical rooms used for medicine storage and noted that the temperature had been recorded at 27 degrees on multiple days over a number of months. Labelling of the medicines showed that storage was required at a temperature maximum of up to 25 degrees Celsius. This posed a risk to the effectiveness of those medications.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Improvement was required to ensure that care plans reflected the current needs of residents, and included information which was person-centred and sufficiently detailed to guide staff in providing good quality care. For example:

- Person-centred behavioural support plans were not in place for two residents who were reported to behave in a responsive manner or posed a risk to themselves or other persons. This meant that there was no clear guidance for staff on how to respond appropriately to their behaviours or identify the triggers and implement effective person-centered de-escalation strategies.
- One resident did not have a care plan in place despite an assessment indicating a risk of exit-seeking behaviour.
- Two residents' assessments recorded they were not at risk of exit-seeking, however they had care plans in place guiding staff on how to prevent and respond to these behaviours.
- A resident's care records documented an ongoing incident which resulted in specific care needs for the resident, however there was no care plan in place to address this identified need.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

As referenced earlier in this report, the person in charge had not ensured that 52% of staff had up-to-date knowledge and skills appropriate to their role in responding to and managing challenging behaviour.

Not all identified behaviours that challenge were managed in the least restrictive manner. Inspectors observed that a resident's risk assessment and care plan directed staff to remove a resident from communal areas at specific times, however there was insufficient information as to why this restriction was required.

Judgment: Substantially compliant

Regulation 8: Protection

All reasonable measures to protect residents from abuse had not been taken. For example:

- One safeguarding risk assessment reviewed outlined specific control measures including supervision and staff training, on topics such as confidentiality, had not been implemented at the time of inspection. Therefore the inspectors could not be assured that all sufficient controls were in place to safeguard residents.

- For four residents with known safeguarding needs, there were safeguarding care plans in place, however they did not clearly outline the safeguarding risk posed to the residents' concerned and what specific steps staff needed to take to protect the resident. Two staff spoken with during this inspection were unaware of the safeguarding measures in place for two out of these four residents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Improvements were required to ensure that residents' rights were promoted and upheld within the designated centre. For example;

- Residents did not have equal opportunities to participate in activities. While inspectors observed engaging activities taking place throughout the day of inspection in communal spaces, not all residents were given the opportunity to participate in the activties. Some residents were observed to be in their bedrooms for the duration of the day. Some of these residents told inspectors that they did not know how to find out what activities were on offer or when they were on.
- Feedback provided by residents through the resident forum meetings was not always addressed or completed to the satisfaction of the residents. This resulted in one resident raising their dissatisfaction about the same aspect of the service on several occasions.
- Some doors to external courtyards and balconies were observed to be locked. This impacted on residents' rights to have unrestricted access to these areas of their home.
- Residents in multi-occupancy bedrooms shared one TV between every two residents. This impacted on the residents' choice of what to view.
- Two residents who spoke with inspectors were unaware that there was a complaints process available to them and therefore were not supported in their right to make complaints about aspects of the service provided to them.

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Phoenix Park Community Nursing Units OSV-0000476

Inspection ID: MON-0044993

Date of inspection: 30/09/2025

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Fire Safety and Safeguarding Vulnerable Adults Training:

• Following this inspection, an audit on all fire training records to identify all staff who were due refresher training was completed. All of the staff identified have now completed Fire Safety refresher training as of 11/12/2025. Rolling training sessions are scheduled to commence in January 2026 to ensure staff are maintained with up to date Fire Safety training.
• Ward CNMs will closely monitor and manage their staff training to ensure all staff remain up to date with mandatory training requirements and will provide monthly assurance to the ADON/PIC.
• Ward CNM's are carrying out an audit of Safeguarding Vulnerable Adults training records of their staff to identify who requires training. All identified staff will be supported to complete the HSELand Safeguarding Vulnerable Adults training module. It is expected this will be completed by end of Q4 2025.
• As an additional control, a random sample of Fire safety Training and Safeguarding Vulnerable Adults training records will be checked during Quality and Safety walk-arounds to identify any compliance issues at the earliest possible stage.

Appropriate Supervision of Staff:

Protection of residents, staff and visitors from the risk of infection:

• ADON/PIC has met with all ward CNMs to ensure all their staff are aware of their individual and collective responsibilities in relation to the correct use of personal protective equipment (PPE) and particularly the correct procedure for donning and doffing of PPE and mask etiquette.
• A broadcast memo from the ADON/PIC to issue to all wards by 21/12/2025 reminding all staff of the AMRIC guidance and to ensure their AMRIC training in particular PPE

refresher training is completed every 2 years.
• ADON/PIC has requested the IPC advisor to do toolbox talks at daily safety huddle on all wards, to increase awareness.
• Masks with clear mouth pieces to be sourced and made available for use with hearing impaired residents by 01/02/2026.

Staff practices- Mealtime experience:

• ADON/PIC met with ward CNMs on 04/12/2025 who have been requested to follow up and discuss the requirement for mealtime experience to be relaxed, social and unhurried and not task orientated with all staff.
• Mealtimes will continue to be supervised and monitored on each ward by experienced staff, with regular spot checks performed by the ward CNM or senior staff in charge to ensure the residents' dignity is always maintained whilst having assistance from staff with meals.
• Mealtime audits have been scheduled to be carried out to independently assess practices during mealtimes by 31/01/2026. Results will be considered by the ADON/PIC and discussed with ward CNMs with corrective actions implemented if required.
• Ward CNMs to ensure all staff have read, understand and comply with the protected mealtime policy and provide assurance to the ADON/PIC.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Safe storage of all records:

• ADON/PIC has requested all ward CNMs to ensure Residents' files are stored securely in locked filing cabinet as per policy; ADON/PIC will also send memo to all ward CNM's by 21/12/2025.
• Safety notices generated and displayed in all wards by 15/12/2025 reminding staff to ensure residents' files are stored securely and filing cabinets are locked when not in use.
• Replacement keys ordered and distributed on 10/12/2025 for filing cabinets which were reported by the ward CNMs to be missing keys.
• Ward CNMs instructed by the ADON/PIC to ensure all ward diaries and handover sheets are not to be left unattended and easily accessible to the public at the nurses stations when not in use.
• Spot checks/ audits have commenced intermittently by ward CNMs to check that filing cabinets are locked and residents' information is not left lying around unattended and easily accessible to the public. These checks will be carried out weekly initially.
• Compliance with this instruction will be a standing item on ADON/PICs monthly meeting with the ward CNMs and monitored during the Quality and Safety walk-arounds.

Completion of records in line with Schedule 3:

• The ADON/PIC has met with the ward CNMs to ensure all their nursing staff are recording clinical practice in line with NMBI Recording Clinical Practice Guidelines 2015 and are aware of the importance of documenting care and safety checks provided to residents in line with this guidance, HSE policy and Schedule 3 requirements.
• In house compliance monitored by the ADON/PIC through Quality Care Metric reports.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The service plan to conduct a review of governance and management monitoring systems in place to oversee the safety of the service, staff practices and monitoring compliance plans including the following:

• An improved monitoring system including management quality walk rounds, review of audits and facilities checks will be formally documented and submitted for approval by the Registered Provider Representative. Timeframe Q1 2026.
• The Director of Nursing/PPIM is responsible for the oversight of the progress and implantation of the compliance plan from this inspection.
• The ADON/PIC will provide status update reports to the Director of Nursing/PPIM to include updates on all actions completed and expected timeframes for outstanding actions.
• Progress and implementation of the compliance plan will be a standard agenda item for discussion at all ADON's/PIC and ward CNMs meetings.

In relation to the specific findings during the inspection note the following actions:

Facilities improvements
• Additional call bells are being installed in public areas across the facility, including: all ward conservatories, the semi enclosed area in Tara ward, the public toilets in Ailbhe ward and Conall ward and foyer areas in both Teach Iosa and Teach Cara, to be completed by end of Q1 2026.
• Pest Control Services have returned again to treat and eradicate nesting wasps. This wasp nest treatment should provide an effective solution to eliminate the wasps and keep our residents and staff safe from the threat of stings. Ward CNMs are aware of escalation process to pest control services and their requirement to escalate to ADON/PIC if any delay in response.
• All sluice room doors are secured with a keypad/swipe card. Ward CNMs have been requested to ensure all staff understand the requirement to ensure doors remain closed all the time.

Care Planning
• CNM will ensure all care plans are updated to reflect current status of residents by the

following:
• Ward CNMs will ensure all care plans are updated to reflect current status of residents, in line with NMBI, HSE and Schedule 3 guidelines. Timeframe Q1 2026
• Care planning remains as a standing item on the Ward CNMs staff meeting agendas.
• Care plan audits continue to be carried out monthly, with outcomes considered by ward CNMs and ADON/PIC and corrective actions implemented as required.
• Quality Care metric reporting will continue to be carried out by ward CNMs monthly, with in house compliance monitored by the ADON/PIC. Peer metrics audits will be carried out 6/12 monthly by the ward CNMs.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The risk management policy was updated to reflect the changes in legislation in June 2025 and circulated to the HIQA readiness working group in July 2025 and approved September 2025.
• The safeguarding policy was updated and circulated to the HIQA working group for consideration in September 2025.
• A memo was sent by the ADON/PIC to all staff to notify them of the updated policies on 16/12/2025.
• The revised policies will be discussed at CNMs meetings and unit meetings.
• Copies of the updated policies are available in the ward policy folders and electronically on the MAPS portal.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As per our earlier response to Regulation 23: Governance and Management, an improved monitoring system including management quality walk rounds, review of audits and facilities checks will be formally documented and submitted for approval by the Registered Provider Representative.

In relation to the specific findings during the inspection note the following actions:

• All broken and damaged furniture identified on inspection has been removed.
• ADON/PIC has requested all CNMs to ensure all equipment and supplies are appropriately stored.

• Ward CNMs will complete facilities checks during their daily ward walk arounds/inspections and escalate issues as per local policy.
• The light switch fixing with exposed wires identified on the day of inspection was immediately addressed with repair completed on 01/10/2025.
• Phase two of the Flooring Replacement and Upgrade Programme of Works in Teach Cara is now at implementation phase, scheduled for completion Q2 2026.
• A full facilities audit will be conducted by the ADON/PIC to ensure all these actions have been implemented. Timeline for completion Quarter 1 2026. With audit outcome submitted to the Director of Nursing/PPIM for consideration and action as required.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
In relation to the specific findings during the inspection note the following actions:
• Building Management System to be upgraded to address temperature regulation in treatment rooms. Work commenced15/12/2025, will take approximately five weeks. Timeline for completion Q1 2026.
• Temperatures in treatment rooms and medication fridges recorded daily, checked by Ward CNMs. Any recordings outside of the required temperature range to be reported as an incident and followed up immediately for action.
• Ward CNMs to ensure all staff have read, understand and comply with the Medication Management Policy and provide assurance to the ADON/PIC.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Noting our response under Regulation 23: Governance and Management, improvements to ensure care plans reflect the needs of residents include the following:
• Ward CNMs will ensure all care plans are updated to reflect current status and care needs of residents, in line with NMBI, HSE and Schedule 3 guidelines by completing a review of all care plans in their wards. A formal report will be issued to the ADON/PIC for consideration and corrective actions implemented as required. Timeframe for completion Q1 2026.
• The ADON/PIC is leading a focused review of care plans for residents who have behaviors that challenge and/or exit seeking behaviors to ensure interventions required

are appropriately recorded and necessary information is shared as part of their individual care needs. Specific gaps in care plans for a small number of residents identified on the day of inspection are included in this review.
• Care planning remains as a standing item on the Ward CNMs staff meeting agendas.
• Care plan audits continue to be carried out monthly, with outcomes considered by ward CNMs and ADON/PIC and corrective actions implemented as required.
• Quality Care metric reporting will continue to be carried out by ward CNMs monthly, with in house compliance monitored by the ADON/PIC. Peer metrics audits will be carried out six monthly by the ward CNMs.

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:
• ADON/PIC will ensure all staff have up to date knowledge and skills appropriate to their role in responding to and managing challenging behavior. Timeline for implementation Q4 2026.
• Training in managing challenging behavior appropriate to the level of risk has been sourced, initial sessions delivered November and December 2025. Further training will be scheduled and delivered on a rolling basis throughout 2026.
• As outlined in Regulation 5 individual assessment and care planning response, the ADON/PIC is leading a focused review of care plans for residents who have behaviors that challenge and/or exit seeking behaviors to ensure interventions required are appropriately recorded and necessary information is shared as part of their individual care needs.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Noting our response under Regulation 16: Training and staff development, in relation to the specific findings during the inspection note the following actions:

• Ward CNMs will closely monitor and manage their staff training to ensure all staff remain up to date with mandatory training requirements and will provide monthly assurance to the ADON/PIC.
• Ward CNM's are carrying out an audit of Safeguarding Vulnerable Adults training records of their staff to identify who requires training. All identified staff will be supported to complete the HSELand Safeguarding Vulnerable Adults training module. It is

expected this will be completed by end of Q4 2025.
• In relation to the specific gaps in safeguarding care plans and risk management for a small number of residents identified on the day of inspection, the ADON/PIC is leading a focused review of care plans for residents who have behaviors that challenge to ensure interventions required are appropriately recorded and necessary information is shared as part of the risk management of their individual care needs.
• Ward CNM's to ensure safeguarding plans are updated to include the safeguarding risk posed to or by the resident, what specific steps are needed to protect the residents and are in line with Designated Officer recommendations.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Improvements to ensure residents' rights are promoted and upheld include the following:

Activities
• Activity staff to continue to call to all residents' rooms to invite them to join in any activities to ensure that all residents are given a choice in whether they attend activities or not.
• An Activity timetable is displayed on each residents' notice boards weekly and outside activity rooms in each building.
• Issues raised at Residents Forum meetings will be tracked and a status report provided to the ADON/PIC.

Access to external courtyard and balconies
• Balcony and Court Yard doors to be open in line with will and preference of residents as below:
o Doors to communal internal gardens shall be opened at 7.30am by night staff effective immediately.
o Staff will ask residents if they wish to have their room balcony door opened.
o Any deviation to this will be documented in a risk assessment.

Access to TVs in shared rooms

• Residents in shared rooms will be asked if they wish to have their own screen. Should this be required a screen will be provided in line with their will and preference.

Complaints

• Ward CNMs will check that each resident is aware of the complaints procedure by 31/01/2026. This will include ensuring each resident has a copy of the Residents guide highlighting where to get information on the complaints procedure (a copy is provided to all residents on admission). Ward CNMs will provide a status report to the ADON/PIC in relation to same.

• YSYS posters are displayed on resident's notice boards on all wards.
• As part of the quality and safety walk arounds on the units residents are asked if they are aware of how to make a complaint. If any residents inform the team they are not aware of how to make a complaint, the team explain the process and inform them how to access the YSYS complaint forms.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2026
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	31/05/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	10/12/2025
Regulation 23(1)(d)	The registered provider shall ensure that management	Substantially Compliant	Yellow	31/03/2026

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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	31/01/2026
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	16/12/2025
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).	Not Compliant	Orange	09/01/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Not Compliant	Orange	31/03/2026

	months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
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	30/09/2026
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	28/02/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	28/02/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in	Substantially Compliant	Yellow	31/12/2025

	activities in accordance with their interests and capacities.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/12/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/01/2026