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:	Midleton Community Hospital
Name of provider:	Health Service Executive
Address of centre:	The Green, Midleton, Cork
Type of inspection:	Unannounced
Date of inspection:	28 October 2025
Centre ID:	OSV-0000579
Fieldwork ID:	MON-0047492

About the designated centre

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

Midleton Community hospital is currently registered to accommodate a maximum of 27 residents; registered predominantly for the care of the older persons however it is registered to care for any person over the age of 18 years, both male and female. The hospital provides 24-hour nursing care provided by a team of doctors, managers, staff nurses, multi-task attendants (MTAs) and other staff members. Resident accommodation comprises single, twin, three and four bedded multi-occupancy bedrooms. All bedrooms have a handwash basin, some have en suite facilities. There are communal toilet, shower and bath facilities in the hospital. Communal rooms include dual purpose day and dining rooms. There is a church on site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	27

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 28 October 2025	09:00hrs to 17:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

From what the inspector observed and what residents reported, they were generally very happy in the centre. There was a calm and welcoming atmosphere throughout the centre, and friendly chats could be heard between residents and staff. Residents said that they could speak with staff if they had any concerns or worries. All interactions observed between residents and staff were calm, gentle, relaxed and respectful. Over the course of the inspection, the inspector met many residents and spoke with 11 residents in more detail to gain insight into their lived experience in Midleton Community Hospital.

Residents were happy with the care and were complimentary in their feedback regarding staff and how kind they were, however, they reported that they were 'sick of waiting' for the new building to be opened. They said 'they keep telling us it won't be long more, and we're still waiting', and 'we've been told that since last year'. They specifically asked the inspector for this feedback to be recorded. The inspector met two family members who were very complimentary of staff and the service provided.

This unannounced inspection was conducted with a focus on adult safeguarding and reviewing the measures the registered provider had in place to safeguard residents from all forms of abuse. There was a relaxed and friendly atmosphere, and staff were seen to promote a person-centred approach to care.

Midleton Community Hospital currently open to residents, comprises two buildings, the front and back buildings, accessible to each other through a back garden and furnished patio area; currently it accommodates up to 27 residents. Bedroom accommodation comprises single, twin, three and four bedded rooms, and all bedrooms have a handwash basin. Renovations and refurbishment had been undertaken in the last number of years to improve the premises, however, as described in all previous inspection reports, the layout and facilities available to residents, did not, and could not meet their individual and collective needs. For example, the small day room facilitating group activities could only be accessed through a four-bedded multi-occupancy bedroom. While privacy curtains were drawn around residents while receiving personal care, residents from other rooms and units were seen to come through this bedroom to access the day room for their daily activities.

There was no designated dining room in the hospital. Communal spaces facilitated both day and dining activities; all communal rooms were small and could only accommodate a maximum of eight residents. Storage space for equipment was limited.

There was directional signage to bedrooms and communal areas to orientate residents and visitors to minimise risk of disorientation and ally confusion. The schedule of activities was displayed on large white notice boards on each unit. They

included the type of activity as well as the person facilitating this. For example, on the day of inspection there was a fit-for-life exercise programme from 11 – 12MD and sing-song from 2 - 4pm with Tony. Several residents were seen reading the newspaper in their bedrooms while having a cup of tea in the morning as part of their preferred daily routine.

An external company provided activities two days a week and hospital staff were allocated to activities on other days, and were written on the white board as well as the duty roster to be assured that residents had access to meaningful activities throughout the week. Both the exercise programme and sing-along with Tony were interactive and seen to be very enjoyable. Residents were encouraged to join in as staff were familiar with residents, their backgrounds and included this as part of positive engagement and encouragement. For example, some residents liked fishing, so Tony reminded them of the fly-fishing motion to exercise their wrist, elbows and shoulders. Similarly, 'kneading bread' exercise reminded residents of that motion getting them moving their wrists and arms as well. Residents were seen to thoroughly enjoy activities and entertainment. Throughout the inspection staff were observed to sit, chat normally and read the news paper for residents during quiet times, and residents appeared to enjoy the socialisation and one-to-one time with staff. Throughout the day, as staff passed through the bedrooms to day rooms, they greeted residents and had a 'word' with each person in a lovely social manner.

After lunch, one resident chose to return to their bedside to watch TV. Staff knew her preferences and had an Andre Rieu concert playing for her as she loved the music and explained that her father played the saxophone and grew up listening to beautiful music. Another member of staff accompanied a resident around the garden and both were well wrapped up as it was a blustery day. As the paths were seen to be quite uneven, residents could not access the outdoors independently.

Photographs of recent celebrations were displayed of different parties and occasions. Information displayed included advocacy services available with contact details and the complaints procedure. There was a church on-site and mass was facilitated there twice a month.

All residents whom the inspectors spoke with were complimentary of the food served. Some resident chose to dine in their bedrooms as there were inadequate dining facilities in the hospital with no separate dining rooms. Communal rooms were small and facilitated both dining and day spaces. Staff were seen to actively engage and support residents in a social manner throughout the day including during meal-times, despite the limited environment. The food served appeared nutritious and appetising. Staff were observed to be respectful, and discreetly assisted the residents during the meal times. The inspector observed that drinks and snacks were offered to residents mid morning and mid afternoon.

The centre was observed to be very clean, and staff were seen to adhere to good hand hygiene protocol.

Emergency evacuation floor plans were displayed throughout the building. They were orientated to reflect their relative position in the centre. Within the floor plans

there were primary and secondary escape routes, exit points and locations of fire fighting equipment to enable a safe evacuation.

Visitors confirmed that there was good communication with staff. Community involvement was evident; the inspector was informed that the fund-raising by "The Friends of Midleton Hospital" was a huge support to the centre and the service.

The next two sections of this report will present findings in relation to governance and management in the centre, and how these impact the quality and safety of the service being delivered.

Capacity and capability

This un-announced inspection was carried out to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations with a focus on safeguarding, and to follow up on the previous inspection judgements. Findings of this inspection were that Midleton Community Hospital was a good service where residents were supported to have a good quality of life.

Issues that remained outstanding were the premises, as detailed in all previous inspection reports. The inadequacy of the premises continued to impact the privacy, dignity and autonomy of residents, in particular, people living in multi-occupancy bedrooms. Communal rooms were dual purpose of day and dining room, they were small and could accommodate a limited number of residents. Notwithstanding the improvement in the decor and refurbishment, the premises could not facilitate a social model of care presumed as part of a residential care setting. The provider, the HSE, had a new purpose-built centre on the grounds of the current centre, which could accommodate all the residents in the current units. This will enhance the lives of the residents going forward. Although the building is complete, to date, an application has not been received by the Office of the Chief Inspector to register this new building.

The Health Services Executive (HSE) is the registered provider for Midleton Community Hospital. The centre is currently registered to accommodate 27 residents. The general manager acts as the named person representing the HSE for the purposes of regulation and registration. On site, the governance and management arrangements were well defined. The care team in the centre comprises the person in charge, two clinical nurse managers 2 (CNMs) and two CNMs1, a team of nurses including senior enhanced nurses and health-care staff, administrative, catering, household and maintenance staff. At a more senior level, senior managers with responsibility for the centre were named as part of the centre's statement of purpose, however, they were not named as persons participating in management on the centre's registration. This is further expanded upon under Regulation 23: Governance and Management.

Schedule 5 policies and procedures were reviewed and policies relating to safeguarding were available to staff; however, some policies these required attention to ensure they complied with the requirements of the regulations. This is further detailed under Regulation 4: Written policies and procedures.

The registered provider had supported staff in reducing the risk of harm and promoting the rights of residents by providing training. Records viewed on inspection showed that staff had completed the human rights-based approach to care, responsive behaviours, safeguarding, restrictive practice and dementia care training, and the inspector observed that staff were knowledgeable and applied the principles of training in their daily practice. As a result, the inspector observed that the outcomes for residents were positive, and that staff and resident interactions were personal and meaningful, upholding the residents' fundamental rights while promoting their privacy and dignity. Further training was scheduled for later in November and December to ensure training remained current for all staff. On the day of inspection, staff duty rosters showed that the service was well resourced.

Minutes of governance and management meetings demonstrated good oversight of operational management of the service. Clinical and non-clinical aspects of the service, complaints, risk, promoting a social model of care, and key performance indicators (KPIs) such as falls and restraint were reviewed and discussed at these meetings. Where actions were identified to improve the service, an action plan was developed with people responsible for completion of the action assigned, and a completion date.

A review of the incident and accident and post falls log showed good oversight of such events. Issues were seen to be followed up thoroughly with action plans to ensure best outcomes for residents. There were no safeguarding concerns currently being managed in the centre; nonetheless, the person in charge was very familiar with her role, responsibilities and reporting requirements associated with safeguarding residents.

The audit schedule was set out at the beginning of the year and aspects of residents' care, infection prevention and control, antimicrobial stewardship, and medication management, for example.

Inspector found that records required by Schedule 2, 3 and 4 of the regulations were available for inspection purposes. Assurance was provided that vetting disclosures, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016, were in place for all staff, prior to commencement of work in the centre. There was a comprehensive complaints management system in place.

Regulation 15: Staffing

The inspector reviewed the staff rosters and saw the centre was well resourced with adequate staff for the size and layout of the centre and the number of residents in

the centre.

Judgment: Compliant

Regulation 16: Training and staff development

From a safeguarding perspective, the provider had ensured that all staff had access to relevant training modules, for example, safeguarding of vulnerable adults, the management of restrictive practices, and the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Ongoing training was scheduled to ensure staff training remained current. Additional training was also provided regarding promoting a human rights-based approach to care.

Staff appraisals were undertaken by the person in charge and CNM2s, and professional development formed part of this supervision. Additional training was facilitated such as palliative care, four staff had completed fit-for-life exercise programme to enable them provide this as part of the activities programme, two staff had completed the infection prevention and control link practitioner, two staff completed the manual handling providing that training on site, and another staff completed the dementia care and responsive behaviour course to enable them provide training on site.

There were arrangements in place for the ongoing supervision of staff, through CNM presence on each unit, and through the induction, probation and performance review process.

Judgment: Compliant

Regulation 23: Governance and management

Action was required to ensure the governance and management of the centre, as:

- senior managers with responsibility for the service (as detailed in the statement of purpose) were not named as persons participating in management. Consequently, it could not be assured that the person in charge was adequately supported by a suitable management team, and be assured that there is a sufficient and clearly defined management structure in the designated centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A review of complaints records showed good oversight and management of complaints. Complaints were recorded in compliance with specified regulatory requirements, followed up and responded to within the allocated time-frame. In general, the person in charge reviewed complaints, followed up with the complainant to ensure they were happy with the process and outcome.

Complaints and how to raise issues were part of residents meetings to ensure residents were familiar with the process and to assure them that they could raise issues as part of their rights as a resident in the centre.

The person in charge and senior management team members had completed training in complaints' management as part of safeguarding residents.

Judgment: Compliant

Regulation 4: Written policies and procedures

Action was required to ensure policies and procedures associated with Schedule 5 were in place, and updated in accordance with regulatory requirements as follows:

- there was no written policy regarding end of life care
- the creation of, access to, retention of, maintenance of and destruction of records was out of date since November 2024.

Judgment: Substantially compliant

Quality and safety

The purpose of this inspection was to review the measures in place to promote and protect people's human rights, their health and well-being. This involved assessing the quality of service being provided to residents to ensure they were receiving a high-quality, safe service that protected them as part of adult safeguarding. This inspection found that there were robust systems in place to recognise and respond to safeguarding concerns in the centre, and to ensure all measures were taken to protect residents from harm. Notwithstanding the positive findings, the inspector found that residents' care planning did not align fully with the requirements of the regulations and this is outlined under Regulation 5: Individual assessment and care plan. As outlined in all inspections of Midleton Community Hospital, the premises did

not and could not meet the needs of all residents due to the lack of appropriate communal space, multi-occupancy bedrooms which impacted their privacy, dignity and autonomy as described heretofore.

The inspector reviewed a sample of residents' care records. Residents documentation showed that they signed consent for care planning and photographic identification. Family members such as spouses were involved in the care planning process and some signed records to say they were involved. All residents had personal emergency evacuation plans that detailed the assistance required for both day and night time to ensure their safety. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Validated risk assessments tools were available to staff to enable a high standard of nursing care assessment. The inspector viewed a sample of residents' safeguarding care plans and the management of behaviours that are challenging care plans including clinical assessment tool to describe the behaviour; these were seen to have excellent insight into residents and their individual care needs, with possible interventions to support the resident to enable best outcomes for them. Observation on inspection showed that staff had excellent knowledge of the resident, their interests and past lives, and used this information to actively engage with residents. Most care plans demonstrated equally good information, and in general, medical histories informed the assessment and care planning process, however, issues were identified regarding care records.These are further detailed under Regulation 5: Individual assessment and care plan.

Residents had good access to medical care, including out-of-hours services. A general practitioner (GPs) was on site twice a week, and one was on site during the inspection. Residents had timely referrals to allied health professionals and specialist services along with accessing services such as diabetic services for example. The pharmacy fulfilled their duties, as outlined in the regulations for the sector. Transfer letters (for occasions when a resident was temporarily transferred to another health care facility) were examined and these were seen to be comprehensive to enable the receiving health care facility care for the resident in accordance with their current needs.

Where restraints, such as bedrails, were used, they were risk assessed. Residents exhibiting responsive behaviour (how residents with dementia respond to changes in their environment or express any distress) were well supported. Staff were observed to respond appropriately to such residents.

There were effective systems in place for the collection and return of residents' clothing and bed linen following laundry in an external service. This service was under ongoing evaluation by the person in charge to ensure the service was effective and met the needs of residents and the hospital.

In general, inspection findings demonstrated that residents were free to exercise choice in their daily routine. It was evident that residents were consulted about the running of the centre, formally, at residents' meetings, and also through the daily interactions with staff and family members.

Regulation 10: Communication difficulties

From observation during the inspection it was apparent that staff were familiar with residents and their individual communication needs; staff supported residents to communication and were seen to take time to listen to residents and actively engage with them in a respectful manner.

Residents were also facilitated to access additional supports, such as assistive technology to assist with their communication.

Judgment: Compliant

Regulation 17: Premises

Regarding the premises:

Notwithstanding the improvements to the physical environment, the premises overall could not meet the individual and collective needs of residents as identified on numerous previous inspections:

- access to some communal space is via multi-occupancy bedrooms impacting residents' privacy and dignity
- the design and layout of the multi occupancy rooms impacted residents privacy and dignity
- residents were unable to use mobile privacy screens independently in multi-occupancy bedrooms. The wall mounted, telescopic, folding screens were difficult to manoeuvre around individual beds. Their design and movement was cumbersome and heavy, meaning that a staff member would have to support a frail older adult to move them around the bed, if individual privacy was required for reading, visiting or sleeping,
- there was a lack of accessibility of toilets for use by wheelchair users
- there was a lack of designated dining rooms and dual purpose communal rooms were small and could only accommodate a limited number of residents
- there was limited storage for equipment
- some doors to communal areas were heavy and not swing-free, and were difficult to use by most residents, in particular, residents with mobility aids or people using wheelchairs for example.

Judgment: Not compliant

Regulation 26: Risk management

There were policies in place relating to risk management and emergency planning; and these were site specific. Audits were completed regarding clinical and non-clinical aspects of the service with action plans in place to address issues identified along with responsibility assigned to named persons, with completion dates. Associated risk registers were updated accordingly. Within residents' care documentation, individual risk assessments and care management plans were in place to inform individualised care.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While most assessment and care planning documentation reflected a comprehensive overview of the information required to ensure residents could be cared for in accordance with their individual needs, some care records did not have this detail, for example:

- a review of one resident's daily flow sheet and associated daily narrative notes showed no intervention despite their being no output recorded for the resident for eight days
- some care plans were not discontinued when the resident no longer required the additional support such as during an infection or when a wound had healed for example, so the care records were misleading,
- wound care records showed that wound assessment records were only completed at the initial stage of wound management and not following change of dressing to determine the status and effectiveness of the dressing to be assured,
- a review of residents' medication management charts showed that some medication administrations were blank so it could not be assured that residents received the appropriate medication to enable best outcomes; some charts were not signed by nurses to confirm they had checked medication patches to ensure safeguarding of effective pain management.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

There were no safeguarding concerns in the centre at the time of inspection. A restraint register was maintained which included both physical and chemical restraint.

Restrictive practices were discussed as the numbers declared as part of the

quarterly notifications were seen to be high. During the inspection, the person in charge, CNMs and the occupational therapist (who was on site during the inspection) reviewed the restrictive practice register, and the numbers were reduced from 20 down to 12 (as they had included residents with just one bedrail in situ). In addition, another four residents would be trialled with a less restrictive support, so it was envisaged that the number of bedrails would be reduced to eight in the weeks following the inspection.

Additional training would be provided to support staff and residents regarding bedrail usage to enable the number to be reduced further as part of safeguarding residents.

Judgment: Compliant

Regulation 8: Protection

The inspector spoke with the majority of residents throughout the day. They said that they were happy in the centre and felt their rights and choices were respected. Residents reported that they felt safe in the centre. Visitors and residents confirmed that they were treated with respect and dignity by staff and by the person in charge.

Any incidents or allegations of abuse were investigated by the person in charge, and referred to appropriate external agencies, for example the safeguarding and protection team and advocacy services, where required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents felt that they could raise concerns about aspects of care in the centre and they felt that support was available from staff. Minutes of residents' meetings showed good information sharing, residents' feedback and input; suggestions raised by residents were followed up and actioned, such as the request for pancakes for tea, going to the shops in Midleton, and one resident's request to go to Killarney for a day.

Group video calls were introduced which enabled family members from diverse locations call their family member to chat together as a family, and this was a huge comfort to all.

Residents had access to advocacy services and the person in charge enabled residents to access this service. Information regarding advocacy was displayed throughout the centre.

The centre was supported by 'The Friends of Midleton Community Hospital'. In recent times they had donated the interactive table which staff reported that this was of huge benefit to many residents, in particular, residents with a cognitive impairment. Staff reported that a few residents that usually would not engage in activities, used this interactive board, and residents enjoyed the activity which increased their motor function as well. Staff said The 'Friends' were sponsoring the residents' Christmas party in the local hotel in December with taxis booked already; residents said they were so looking forward to it as they had a great time in the hotel during the summer.
Judgment: 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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Midleton Community Hospital OSV-0000579

Inspection ID: MON-0047492

Date of inspection: 28/10/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The person who is participating in the management of the Midleton Community Hospital is the Person in Charge and their qualifications have already been submitted to the Chief Inspector pursuant to Section 49(1)(b)(ii). The Person in Charge is supported by the Older Persons Services (General Manager and the Head of Service), HSE South West. • The proposed Integrated Healthcare Areas restructuring will take place in the first quarter of 2026. ***The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations***.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Following the inspection, all policies have been reviewed and are now available in the policy folder for both the front and back hospital buildings. • The DON will ensure that all policies remain up to date. • The DON and CNM2s will conduct regular policy audits.	

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Midleton Community Hospital endeavours to continue upholding residents' privacy and dignity.
• While the existing hospital building design and layout present certain limitations these will be addressed with the upcoming move to the PPP once registration has progressed.
• Staff are committed to supporting residents' needs at all times. Where residents require privacy for reading, visiting, or sleeping, staff will promptly provide assistance with available privacy screens and take all possible measures to ensure comfort and dignity. MCH will continue to seek feedback from residents and families regarding of their privacy and dignity, and to identify and action further improvements required. Additionally, to address the limitations of the existing hospital building and enhance the residents' privacy and dignity, a new purpose-built Community Nursing Unit has recently been built on campus. This new facility is designed to provide improved privacy, dignity, and accessibility for all residents, offering modern en-suite single rooms and communal areas that do not compromise residents' personal space. We are hopeful that this new unit will be ready for occupancy in the first quarter of 2026.
• The new facility is equipped with a spacious dining area and several communal sitting rooms, providing residents with comfortable spaces to relax, enjoy meals, and socialise with others.
• Residents who use wheelchairs will be supported in accessing the designated fully accessible toilets. A sign has been installed to direct residents to these facilities. MCH will ensure residents have access to accessible toilets as needed.
• The door closure to the communal room was replaced with a swing-free closure on 20 November 2025 to improve accessibility for residents.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
While most assessment and care planning documentation supports person-centred care, we acknowledge the highlighted gaps. To address these issues:
• Staff will be reminded during daily handovers and ward meetings about the importance of timely and accurate documentation, especially for residents' daily outputs, wound care interventions, and medication administration.
• Wound care practices have been improved by ensuring a wound assessment is completed after each dressing change to determine the wound status and effectiveness of the dressing. This process will be reminded to all staff at the daily safety pause.
• The importance of complete and accurate medication administration and documentation will be communicated to all staff by providing additional reminders to

ensure nurses consistently sign medication charts to confirm medication patch checks, ensuring effective pain management for all residents. This will be reminded at the daily safety pause meeting.

• We have implemented weekly spot checks and monthly audits of randomly selected care plans, daily flow sheets, wound assessments, medication administration, and documentation. These measures help ensure that assessments and care plans remain up to date and that medication administration is accurate.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	05/12/2025
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Substantially Compliant	Yellow	31/03/2026
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out	Substantially Compliant	Yellow	30/11/2025

	in Schedule 5.			
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	30/11/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	05/12/2025