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:	Áras Deirbhle Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Aras Deirbhle, Belmullet Community Hospital, Belmullet, Mayo
Type of inspection:	Unannounced
Date of inspection:	13 November 2025
Centre ID:	OSV-0000644
Fieldwork ID:	MON-0045416

About the designated centre

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

The following information has been submitted by the registered provider and describes the service they provide. The designated centre provides 24-hour nursing care to 30 residents aged 65 and over, male and female, who require long- and short-term care, including dementia care, convalescence, palliative care, and psychiatry of old age. The centre is a single-story building opened in 1975. Accommodation consists of seven twin bedrooms and sixteen single bedrooms. Communal facilities include a dining/day room, an oratory, a visitors' room, a hairdressing salon, a smoking room, and a safe internal courtyard. Residents have access to three assisted showers and two bathrooms. The philosophy of care is to embrace ageing and to place the older person at the centre of all decisions regarding the provision of the residential service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

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
Thursday 13 November 2025	09:00hrs to 16:45hrs	Celine Neary	Lead
Friday 14 November 2025	08:45hrs to 13:00hrs	Celine Neary	Lead

What residents told us and what inspectors observed

The inspector observed interactions between staff and residents to be kind and respectful. Residents spoken with were very complimentary about the staff in the centre. One resident said "staff are lovely and very kind to me" while another resident said "It's not home, but I'm happy here", " I'm well looked after". It was evident that residents were well-cared for and content in their home. Staff interactions with all residents were observed throughout the two days, and the inspector found that staff were always kind and patient in their approach with residents.

Aras Deirbhle is a community nursing unit operated by the Health Service Executive (HSE) and located on the campus of Belmullet Community Hospital. The facility is situated on the outskirts of Belmullet town in County Mayo overlooking the Atlantic ocean. This location provided lovely views of the surrounding coastline and countryside. It is a single storey building and the accommodation comprised of seven twin en-suite rooms and 16 single rooms. The layout also included a large day room which looked out to the sea, a welcoming visitors room, an oratory, a hairdressing room and a reception area. Residents had unrestricted access to a secure internal courtyard, which was paved and had seating areas for residents and their visitors to use and enjoy. This area was decorated with shrubbery and ornaments. This space also included a hut which added interest to the area.

The inspector arrived unannounced at the centre during the morning. The inspector had the opportunity to observe and assess the lived experience of residents in the centre. On arrival at the centre, the inspector met with one of the registered nurses on duty. This nurse was busy with their morning tasks and was in the process of inducting a new agency nurse to the designated centre. The inspector asked for the person in charge and was advised that they were in their office at Belmullet Community Hospital, which is a separate building adjacent to the designated centre. The nurse on duty advised that they would telephone the person in charge and let them know of the inspector's arrival to the centre. After some time waiting, the inspector approached the nurses' office again to enquire if the person in charge was available. The inspector was informed that the person in charge was not on duty nor was the clinical nurse manager. This led to significant delays in obtaining information and records required to carry out the inspection.

Activities were provided in the day room. There was an activities schedule on display and on the day of the inspection some residents were were observed watching mass, reading and participating in games. A member of staff was allocated to provide activities each day.

The inspector walked around the centre and found it to be exceptionally clean. Residents were observed in the communal day room, and some had chosen to remain in bed resting. These personal choices were respected by staff and

facilitated. There was a friendly, relaxed and calm atmosphere throughout. Overall, the inspector found the premises were well laid out to meet the needs of the residents and to encourage and aid the residents' independence. The communal area was a large, bright space with panoramic views of the ocean. It was nicely decorated with comfortable furnishings, a fire place, book shelves and included a domestic-style kitchen area.

Residents had unrestricted access to a secure internal courtyard, which was paved and had seating areas for residents and their visitors to use and enjoy. This area was decorated with shrubbery and ornaments. This space also included a hut, which added interest to the area.

Call-bells were available throughout the centre, and the inspector found that these were responded to in a timely manner.

Activities were provided in the day room. There was an activities schedule on display and on the day of the inspection, some residents were observed watching mass, reading and participating in games. A member of staff was allocated to provide activities each day.

The inspector observed the mealtime dining experiences and saw that residents were offered a choice of main meal and dessert. A selection of drinks was available during mealtimes and throughout the day for residents to enjoy. Residents who required help were provided with assistance in a discreet and patient manner. Staff members supported other residents to eat independently, and residents were not rushed. The atmosphere in the dining room was social, whilst the communal seating areas provided a quieter environment. Staff and residents were observed to chat happily together, and all interactions were respectful. It was evident that residents were comfortable and content in the presence of staff. The daily menu was on display. The meals served were well presented and there was a good choice of nutritious food available. Both the kitchen staff and care staff were familiar and aware of each resident who had specific dietary requirements.

The next two sections of the report present 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. The levels of compliance are detailed under the individual regulations.

Capacity and capability

This inspection found that the governance and management structure, and some systems in place, required strengthening to ensure the quality and safety of the service provided. Significant action was required to comply with the regulations pertaining to governance and management, records, staff training and development,

directory of residents, written policies and procedures and individual assessment and care plans.

This was an unannounced inspection which was carried out over two days by an inspector of social services, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended).

The registered provider for this centre is the Health Service Executive (HSE). As a national provider involved in providing residential services for older people, the designated centre benefits from access to and support from centralised departments such as human resources, training, accounts and maintenance. However, this inspection found that the governance and management systems in place were not robust or in line with the provider's Statement of Purpose

According to the provider's Statement of Purpose, the management structure consisted of a service manager, who represented the provider, a manager of older persons' services who participated in the management of the centre, a person in charge (PIC) and two clinical nurse managers. The management team had responsibility for overseeing the work of a staff team of nurses, health care assistants, multi-task attendants, cleaning and laundry, catering and administration staff.

Senior staff who spoke with the inspector upon arrival at the designated centre, were unsure whether the person in charge was on-duty that morning. There was no person in charge or clinical nurse manager on duty. The senior nurse on duty told the inspector that they worked part-time in the centre and that they were busy inducting an agency nurse who had not worked in the designated centre before. These arrangements were not appropriate and did not support effective oversight and governance and management of service.

The person in charge of the designated centre also had the operational and clinical responsibility of managing Belmullet Community Hospital, a separate building within walking distance of the designated centre. The person in charge was not on the roster available in the designated centre. The inspector had to request the roster for the person in charge, which was located and kept in the district hospital. This roster recorded the hours of duty for the person in charge, but was not available to staff in the designated centre on the day of inspection. The person in charge confirmed that they was based in an office in the Community Hospital on the campus and that they attended the designated centre for a part of each day, and at that other times they were contactable by telephone.

There were significant delays in obtaining information required to carry out the inspection, and as a result, a second day of inspection had to be scheduled. The person in charge was not on the roster for the designated centre. The inspector had to request the roster for the person in charge, which was located and kept in the district hospital. This roster recorded the hours-of-duty for the person in charge, but was not available to staff in the designated centre on the day of inspection.

There was one clinical nurse manager's role vacant since before January 2023, and this resulted in an increased workload on the management team working in the centre. In addition, as seen on the day of the inspection, when the PIC or the clinical nurse manager were off duty, there was no other manager available to oversee the quality of the service and provide adequate supervision and support for the staff.

Although there were improved processes in place, and audits were completed to monitor the quality and safety of the service and residents' quality of life, these processes were not sufficiently comprehensive or robust to ensure that all deficits in the service, were identified and addressed. This is a repeat finding from the last inspection.

Systems to ensure effective allocation of staffing resources provided were not in place and did not ensure the effective delivery of care in accordance with the provider's statement of purpose and the needs of the residents accommodated in Aras Deirbhle Community Nursing Unit. There was an over-reliance on agency staff to cover vacant roles, planned leave, study leave and sick leave. This added to the workload of the permanent staff working in the centre.

A training matrix was maintained by management to monitor staff attendance at training provided. From a review of these training records, some staff working in the centre were not up-to-date with mandatory training, such as manual handling, safeguarding and basic life support. All staff had completed their annual fire safety training.

Staff did not have access to a copy of the Health Act, the regulations made under it or the relevant standards set and published by the Authority. The nursing staff supervised the health and clinical care provided to residents, but there were multiple occasions within the centre where clinical staff were not supervised or supported by their management team.

Written policies as required by Schedule 5 of the regulations were available to staff to inform their practice and were implemented. However, these policies had not been reviewed at the minimum three yearly intervals.

Not all records were held securely in the designated centre or available for the purpose of inspection. A person participating in the management of the centre located some of these records on the first day, and the remainder was submitted to the Office of the Chief Inspector following the inspection.

A directory of residents was available for review and met the requirements of Regulation 19. However, this directory was not kept in the designated centre. It was kept in the Community Hospital.

A review of the complaints log found that the centre had a low level of complaints. A record of complaints made by residents and relatives, was maintained as required. It was evident that complaints were addressed when they came to the attention of the

clinical nurse manager. However, a summary of the complaints procedure was not on display in the centre.

Regulation 16: Training and staff development

The provider had not ensured that all staff had access to appropriate training in line with their roles and responsibilities. Significant numbers of staff required refresher training in safeguarding residents from abuse, basic life support and manual handling.

There were multiple occasions where there was no senior management team on duty within the centre to supervise and support staff appropriately. A review of the duty rosters from September 2025 to November 2025, identified 10 occasions where there was no clinical nurse manager or person in charge on site to supervise and oversee the clinical care provided.

Staff did not have access to a copy of the Health Act, the regulations made under it or the relevant standards set and published by the Authority.

Judgment: Not compliant

Regulation 21: Records

The registered provider did not ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. For example:

- Staff files and the directory of residents were stored in Belmullet Community Hospital and some fire safety records were kept remotely on a separate Information Technology system. These fire safety records were not available to the person in charge in the centre or the inspector for review. The provider submitted these records following the inspection.
- A record of complaints was not made available to the inspector during the inspection but was submitted to the Office of the Chief Inspector following the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

The provider did not ensure that the centre had sufficient staffing resources allocated to ensure the effective delivery of care in accordance with the statement of purpose (SOP). For example:

- The inspector identified that there were two vacant healthcare assistant (HCA) posts, and these were covered by agency staff on a daily basis each week. A further two staff were on long-term leave.
- Nursing roles were covered by agency staff three to four days each week.
- The role of clinical nurse manager (CNM) has been vacant since January 2023 and has not been filled.
- The number of staff available in the centre was not sufficient to cover absences such as planned and unplanned leave. The contingency plan to use agency staff to cover these absences was not sustainable and placed a greater workload on the permanent workforce based in the centre.
- The role of porter was shared with the community hospital and included supporting nursing and care staff in the provision of direct care in the designated centre, as well as general portering duties across both the designated centre and community hospital.

There was not a clearly defined management structure in place that identified the lines of authority and accountability and detailed responsibility for all areas of care provision. For example:

- The person in charge had a dual role as they were also based in and working as the director of nursing in Belmullet Community Hospital. Staff in the designated centre, confirmed that the person in charge was involved in the governance, operational management and administration of the Belmullet Community Hospital, which was not part of the designated centre. Although the person in charge was known to residents, families and staff in the designated centre, there was little evidence that they were sufficiently involved in the overall daily governance and management of the designated centre.

Governance and management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The person in charge was not included on the roster for the designated centre. The roster for the person in charge was kept in the Belmullet Community Hospital. Staff on duty were not aware that the person in charge was not available on the first day of inspection.
- The inspector found that the provider's audit system required review. The audit schedule was not available to view on the day of the inspection. Audits viewed were not measured to inform ongoing quality and safety improvements in the centre. For example, there was no record of audits of key areas such as falls, challenging behaviours, restraints, skin integrity, wound care or nutrition.

- The oversight of records management required review, as important records were not kep in the designated centre as outlined under Regulation 21: Records.

There was no annual review completed for 2024, nor there was a quality improvement plan developed for the service with consultation with residents and their families.

Judgment: Not compliant

Regulation 34: Complaints procedure

A summary of the complaints process was not on display in the centre to inform residents or relatives on how or to whom to make a complaint.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had not reviewed several policies and procedures at the required three-yearly intervals. For example, the policies on admissions, restrictive practices, discharge or transfer of residents and end of life care had not been updated within the last three years.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The Directory of Residents was not maintained in the designated centre. It was kept in Belmullet Community Hospital. It was not available when requested by the inspector.

Judgment: Not compliant

Quality and safety

Overall, residents received a good standard of care in this centre. There was evidence of communication and consultation with residents, and the majority of residents spoken with in this centre felt that they received a good standard of service. Residents spoken with confirmed that they felt safe in the centre and that they found the staff approachable. Residents stated that they would have no problem in making a complaint and that issues were usually addressed promptly. However, action was required in some areas to ensure that the needs of residents were consistently met and that the service provided was safe and residents' needs were met.

The inspector reviewed a sample of care files and found that all residents had care plans in place. However, there were no pre-admission assessments available for review, and there was a lack of evidence that care plans had been reviewed with them or their nominated support persons.

Residents had timely access to their general practitioners (GPs), and a range of specialist medical and health services. Records showed that residents were referred in a timely manner, and where a specialist practitioner had prescribed a course of treatment, this was implemented. Residents had access to physiotherapy, occupational therapy and the provider had since put measures in place to ensure that residents had access to a dietetic service, if required.

The atmosphere in the centre was calm and welcoming, and residents with responsive behaviours (How people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) had additional support in place. A member of staff was allocated to support two residents with responsive behaviours, to maintain their safety and provide care, and to maintain the safety of other residents. The arrangements in place to manage and respond appropriately to residents presenting with responsive behaviour were in line with national best practice guidance. Care plans were seen to outline de-escalation techniques, and ways to effectively respond to behaviours.

The location, design and layout of the centre were generally suitable for its stated purpose and met residents' individual and collective needs. The centre was observed to be safe, secure and well-maintained with appropriate lighting and heating. For the most part, the provider had ensured that the premises were in a good state of repair and were adequately maintained for the comfort and safety of residents. An enclosed courtyard garden area was available for residents to use and this area had unrestricted access.

Residents had access to a smoking room that was located within the building. The inspector saw that this room was fitted with an extraction fan and an automatic door closure. However, the ventilation system was not effective, which resulted in the lingering smell of smoke in the adjoining areas of the centre.

In general, there was good fire safety management observed. For example; escape routes were kept clear, day-to-day in house fire safety checks were completed and were up to date.

Regulation 28: Fire precautions

All staff were trained in the fire safety procedures, including the safe evacuation of residents in the event of a fire. Regular fire evacuation drills were undertaken, including night-time drills. Each resident had a personal evacuation plan in place. There were evacuation sheets on a sample of beds checked by the inspector. There were adequate means of escape, and all escape routes were unobstructed and emergency lighting was in place. The smoking room contained appropriate fire fighting equipment and a protective apron. Fire fighting equipment was available and serviced as required. Fire safety management checking procedures were in place.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Although there had been significant improvements found in care planning documentation since the last inspection, several individual assessments and care plans did not contain their pre-admission assessments.

There was no evidence in the care plans that residents or their significant others were involved in the care planning process.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to access a range of health and social care expertise. Where residents required further health and social care expertise, they were supported to access these services. There was a low incidence of pressure ulcer development within the centre, and wound care practices were found to be based on evidence-based nursing practices.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

A very small number of residents experienced intermittent responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Staff were observed to maintain a positive and supportive person-centred approach towards residents who experienced responsive behaviours. Behavioural support care plans were in place for residents predisposed to responsive behaviours, which guided staff in the best approach to support and respond to these effectively to these behaviours.

A significant number of bed rails were in use, but assessments had been completed which included a multidisciplinary approach in consultation with the resident or their representative, the resident's general practitioner (GP) and the physiotherapist. Regular assessments were completed to ensure continued use of the bed rails was necessary. Procedures were in place to ensure residents' safety when restrictive equipment was in use and to ensure that use was not prolonged.

Judgment: Compliant

Regulation 8: Protection

The centre had policies and procedures in place to protect residents from abuse. Staff spoken with were knowledgeable regarding recognition and responding to abuse. Staff were aware of the reporting procedures and clearly articulated knowledge of their responsibility to report any concerns they may have regarding residents' safety. Residents confirmed that they felt safe in the centre.

Judgment: Compliant

Regulation 18: Food and nutrition

Daily menus were displayed on a notice board in the dining room, and residents were given a choice at mealtimes. There were adequate numbers of staff available to assist residents with their meals. Assistance was offered discreetly, sensitively and individually. Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required. The food offered was plentiful and appeared nutritious. Residents appeared to enjoy their dining experience.

Judgment: Compliant

Regulation 27: Infection control

The inspector found that there was good practice in relation to infection prevention and control (IPC). The management team in this centre had the expert support from an HSE Clinical Nurse Specialist in infection prevention and control. Multiple audits relating to IPC had been completed, and there was good oversight of key areas relating to preventing and controlling infection-related conditions. There were sufficient dedicated hand-wash sinks and hand sanitising gels available. An infection outbreak had been well-managed in June 2025, and residents had recovered.

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 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 19: Directory of residents	Not compliant
Quality and safety	
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Compliant

Compliance Plan for Áras Deirbhle Community Nursing Unit OSV-0000644

Inspection ID: MON-0045416

Date of inspection: 14/11/2025

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Refresher training for staff as identified is in progress and is scheduled for completion by 26-2-2026 A copy of the Health Act, Regulations thereunder and standards is now available in the nurses office Both the Director of Nursing and CNM 2 are rostered and present in the centre. Outside of those times there is an enhanced Senior Nurse on duty.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Directory of Residents is now held in the centre. All staff files will be made available as required. The Fire safety records referred to are now accessible in the centre	

Regulation 23: Governance and management	Not Compliant

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

At present we have to operate within HSE pay and numbers restrictions. We have sought approval for the CNM1 position.
At present 8 beds are closed within the unit due to these restrictions.
We are filling posts through agency conversion and recruitment where a position becomes vacant under the HSE pay numbers strategy. Posts where staff are on long term sick leave/short term sick leave can only be filled by agency as they are not vacant. The use of Agency staff is dependent on HSE staff being available to work and at the time of inspection was as reported due to same. There are no deficiencies in daily staffing that could impact residents ongoing care or welfare.

The Person in Charge is now identified on the roster in the centre. They are onsite daily and available. A summary record of attendance and duties undertaken is now maintained by them.

The audit process is being reviewed and strengthened to ensure the deficiencies identified are addressed.

The annual review is being completed at present and due for finalising by 26-2-2026.

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 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Complaints procedure is now on display in the centre

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

Revisions of policies as identified are being completed at present and are expected to be completed on or before 26-2-2026

Regulation 19: Directory of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:

The Directory of Residents is now held in the Centre.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

We have reviewed all care plans and ensured that individual assessments area all up to date.
We will ensure our consultation with residents and significant others are more comprehensively documented as part of our ongoing review of care plans
Of residents in quarter 1 of 2026.

We have added the omitted pre admission information received or documented before admission to files where available. These include discharge information from acute sector, District Hospitals, Community healthcare providers or other designated centres from where we admit. No person is admitted without thorough assessment by either PIC or CNM2 as to their suitability. All such documentation will be added to files going forward for new a admission at the time of admission.

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.	Not Compliant	Orange	26/02/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/01/2026
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Not Compliant	Orange	30/01/2026
Regulation 16(2)(a)	The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.	Not Compliant	Orange	23/01/2026
Regulation 19(1)	The registered provider shall establish and maintain a Directory of Residents in a designated centre.	Not Compliant	Orange	23/01/2026

Regulation 19(2)	The directory established under paragraph (1) shall be available, when requested, to the Chief Inspector.	Not Compliant	Orange	23/01/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	23/01/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	23/01/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/03/2026
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.	Not Compliant	Orange	30/01/2026

Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/01/2026
Regulation 23(1)(e)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	26/02/2026
Regulation 23(1)(f)	The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with residents and their families.	Not Compliant	Orange	26/02/2026
Regulation 23(1)(g)	The registered provider shall ensure that a copy of the review referred to in subparagraph (e) is made available to residents and, if	Not Compliant	Orange	26/02/2026

	requested, to the Chief Inspector.			
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Not Compliant	Orange	26/02/2026
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position in the designated centre, and where the provider has a website, on that website.	Substantially Compliant	Yellow	23/01/2026
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	26/02/2026

Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	30/01/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/03/2026