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:	St Patrick's Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Summerhill, Carrick on Shannon, Leitrim
Type of inspection:	Unannounced
Date of inspection:	03 February 2026
Centre ID:	OSV-0000661
Fieldwork ID:	MON-0047340

About the designated centre

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

The designated centre provides 24-hour care to 46 residents, male and female, primarily requiring nursing and/or palliative care. Some have a diagnosis of dementia, and others are young, chronic sick persons under 65 years of age. The centre is made up of three units located on the ground floor of a two-storey building, which was formerly a hospital. Two of the units, accommodating 14 residents in each, are mainly for long-term care, and a specialist dementia unit (SDU) accommodates 18 residents. Three beds in the SDU are for residents requiring respite or assessment on a short-term basis, and one designated bedroom is for residents receiving end-of-life care. The aim of the centre is to provide a residential setting where residents are cared for, supported and valued within a care environment that promotes their health and well-being.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

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 3 February 2026	09:00hrs to 16:00hrs	Catherine Connolly-Gargan	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out to monitor the provider's compliance with the Health Act (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended), with a focus on adult safeguarding and the measures the provider had in place to safeguard residents from all forms of abuse in the designated centre. Most residents told the inspector they were generally happy living in the centre, were well cared for and that staff were responsive to their needs for assistance without delay. Residents said that they felt safe and were comfortable living in the centre. The inspector observed that while the service provided and residents' care was, for the most part, organised around residents' individual preferences and choices, improvements were necessary to ensure residents with dementia were adequately supported to participate in meaningful social activities in line with their preferences and capacities. Improvements were also necessary ensure that one-to-one enhanced care arrangements were person-centred and supported residents' independence and autonomy.

On arrival, the inspector was met by the clinical nurse manager (CNM), and by the person in charge a short time later. The inspector completed a walk around the centre and observed that a number of residents were preparing to get up either by themselves or with the assistance of staff, while other residents continued sleeping as they wished. Residents told the inspector that they made their own decisions regarding when they got up in the mornings and when they went to bed. One resident said they continued their usual routine before coming to live in the centre with getting up early in the morning.

The inspector observed that while most staff knew residents well and observed staff interactions with residents were respectful, kind and mostly person-centred, residents' care in the Monsignor Young unit was mainly focused on providing tasks of care. This approach to care was observed to be combined with limited opportunities for the residents in this unit to participate in social activities that suited their capacities and in line with their preferences. As a result the inspector observed that most of the residents who spent time in the sitting room during the day were either intermittently sleeping or sitting quietly watching staff and other residents coming into and leaving the sitting room. A trolley with a computerised interactive games programme was available in the sitting room and a staff member was observed to encourage one resident to participate in the games, while the other residents looked on without an alternative activity being available to them.

St Patrick's Community Hospital is located on the perimeter of Carrick on Shannon town, and within walking distance to the shops, church and other amenities. The designated centre is located on the ground floor, and access to the designated centre is shared with a step-down unit located on the first floor operated by the acute hospital services. The designated centre is comprised of three separate units known as Sheemore, Dr McGarry and Monsignor Young units. Monsignor Young unit

can accommodate up to 18 residents, Dr McGarry Unit had accommodation for 12 residents and Sheemore Unit has accommodation for 11 residents.

The residents' lived environment, including their bedrooms and communal areas, were generally well maintained, visibly clean, bright, homely, warm and comfortable. The provider had repaired damaged areas of the floor covering on the corridor in Monsignor Young unit and, completed painting to the doors on the Sheemore unit since the last inspection. Residents has access to a number of safe outdoor areas, as they wished.The inspector observed that the layout of the residents' bedrooms ensured residents could move around their bedrooms safely, and as they wished. Many of the residents had personalised their bedrooms with family photographs and other personal items. Residents' lockers were located within close proximity to their beds to support them to easily access their possessions when they were resting in bed.

There were a number of communal rooms available in each of the three units for the residents' use. The communal rooms in all three units were well-decorated with traditional memorabilia that was familiar to the residents to support their comfort. However, the inspector observed that there was only one table available and all the spaces around the table were occupied during mealtimes in Dr McGarry unit. As a result, the other residents had their meals served to them on mobile tables placed in front of the chairs they were resting in. Two residents were observed eating their meals from a low table placed between their chairs in the communal room. One resident told the inspector they were eating their meal, while sitting in a comfort chair along the perimeter of the room because they was not enough room for them to sit at the dining table provided. This did not ensure residents' right to make choices regarding where they ate their meals, including at a dining table as they wished.

The inspector observed that there were no unnecessary restrictions on residents in their lived environment. Monsignor Young unit is a dementia specific unit, and access is controlled to this unit and supported with risk assessments of residents' needs to ensure their safety. The layout of the corridors and residents' accommodation supported their safe access around the centre as they wished. Residents in each of the three units could access safe outdoor areas, as they wished.

Residents told the inspector that they felt safe in the centre, and that they would speak to a staff member or their relatives if they had any concerns or were dissatisfied with any aspect of the service they received.

The next two sections of the report will 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. Areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that this designated centre was generally well-managed, and that the management and staff were committed to providing a good service to residents to meet their needs. Although the management team were proactive in responding to deficits identified in service quality and safety monitoring, this inspection found that further actions were necessary to improve residents' quality of life in the centre and to adequately support residents with living their best lives.

While this inspection focused on residents' safeguarding, the inspector also followed up on the provider's progress with completing the actions committed to in the compliance plan from the previous inspection in February 2025, and found that all actions were completed. However, this inspection found that compliance was not sustained in a number of the regulations assessed and further actions were necessary to ensure that the service provided for residents living in the centre effectively met their needs.

The registered provider of St Patrick's Community Hospital is the Health Service Executive (HSE), and a service manager was assigned by the provider to represent them. As a national provider involved in operating residential services for older people, St Patrick's Community Hospital benefits from access to and support from centralised departments such as human resources, information technology, fire and estates, staff training, clinical practice development and finance. The centre's local management structure consisted of a person in charge supported by an assistant director of nursing (ADON) and clinical nurse managers (CNMs) on each of the three units. The management team oversaw the work of a staff team of nurses, health care assistants, activity staff and catering and cleaning staff.

The provider had systems in place to support oversight and monitoring of the quality of care and safety of services provided for the residents. While the quality assurance processes were mostly informing improvements in the service, these processes were not identifying deficits in the standard of residents' social care, and this was negatively impacting on their rights and the quality of their lives in the centre.

Although the provider had arrangements in place to ensure that there was adequate staff available to meet residents' needs, this inspection found that these arrangements were not effective as staff did not have the necessary skills to ensure the social care needs of residents, and in particular, residents with dementia were adequately met. As a result, many of the residents were not adequately supported to participate in meaningful social activities in line with their individual preferences and capacities.

The provider ensured that staff had access to, and opportunities to attend a range of training and development programmes to support them in their respective roles, including training to support staff with safeguarding residents from risk of abuse and

with promoting their rights. All staff had completed training on identifying, preventing, and reporting abuse, human rights training, and training to ensure they has the necessary skills to support and care for residents living in the centre who were predisposed to experiencing responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). However, staff training opportunities did not include appropriate training to ensure staff had sufficient knowledge and skills to support residents' social care needs and that they were adequately met. Additionally, actions were necessary to ensure staff were appropriately supervised to ensure they carried out their role to the required standards. These findings are discussed further under Regulation 16: Training and staff development.

The provider had arrangements for recording accidents and incidents involving residents in the centre. All accidents and incidents were investigated, actions were implemented to mitigate risks identified, and learnings were communicated. However, the centre's risk management policy did not reference information regarding controls in place to manage a number of risks discussed further under Regulation 26: Risk management in the Quality and Safety section of this report.

Regulation 14: Persons in charge

The person in charge changed on 17 November 2025. The new person in charge is a registered nurse, and has required qualifications and management experience in residential care including in a person in charge role.

Judgment: Compliant

Regulation 15: Staffing

While there was sufficient numbers of staff available on each of the three units providing accommodation for residents, staff were not appropriately skilled in providing social activities to meet the needs of many of the residents, including residents with complex needs and residents who wished to spend much of their day in their bedrooms.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Care staff who spoke with the inspector were not able to clearly describe their roles and responsibilities in relation to providing a programme of meaningful social activities for the residents. Furthermore, these staff did not have access to appropriate training in relation to this aspect of their role. As a result, the inspector found on this inspection that there were limited opportunities available for many of the residents to participate in meaningful social activities in line with their preferences and capabilities, especially in the Monsignor Young dementia-specific unit.

Staff were not appropriately supervised according to their roles to ensure that they carried out their work to the required standards. As supervision of staff was not adequate, the inspector found the following;

- Residents were not adequately supported by staff to ensure their social care needs were met to the required standards, and in line with their preferences as described in their care plans. This was negatively impacting on many of the residents' quality of life and rights in the centre.
- Residents' safeguarding documentation was not completed to the required standards to ensure known safeguarding risks were clearly identified and effectively mitigated.
- Practices by staff carrying out enhanced supervision roles for two residents in Monsignor Young unit for periods of 16 hours per day for one resident and 24 hours for the other resident did not promote these residents' independence and autonomy.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider's governance and management systems were not effective in some areas to ensure that the service provided to residents was safe, appropriate, consistent and effectively monitored. The monitoring and oversight systems in place were not effective as follows:

- The management systems for staff supervision and oversight of their practices were not effective, as evidenced under Regulation 16: Training and staff development.
- Oversight of residents' care failed to identify that residents did not have adequate dining facilities in Dr McGarry unit.
- Auditing of residents' assessments and care plans failed to identify that residents' care documentation was not completed to the required standards. For example, not all residents' capacity to participate in social activities they preferred was assessed and safeguarding plans were not consistently developed for residents with known safeguarding needs. This posed a risk that relevant information regarding each resident's safety needs and care

interventions would not be available to staff, and these needs would not be effectively met.
- Management systems in place did not identify and ensure that residents, including residents with dementia were provided with opportunities to participate in meaningful social activities in line with their individual preferences and capacities.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that the management and staff were working to provide a service to residents that promoted the FREDA principles (internationally recognised framework of five human rights concepts used in health and social care) of fairness, respect, equality, dignity, and autonomy to ensure residents were adequately supported to live their best lives, as they wished and protected from risk of harm and abuse. However, actions were found to be necessary to ensure residents' social care needs were adequately supported with meaningful opportunities to participate in social activities that they preferred and in line with their capacities.

This inspection found that residents mostly received good standards of nursing and health care to meet their needs. Residents' records and their feedback to the inspector confirmed that residents had timely access to their general practitioners (GPs), specialist medical and nursing services, including psychiatry of older age, community palliative care and health and social care professionals as necessary. Residents' care needs were regularly assessed, and most residents' care plans were detailed with person-centred information that guided staff and clearly informed most residents' care and safety needs. However, gaps were evident in a number of residents' social care assessments, care plan documentation and records of social care provision. These deficits were also evident in the standards of residents' social care provision on the day, and did not ensure residents' needs and rights were adequately met.

The provider had measures in place to safeguard residents from harm abuse, but gaps in the policy to guide risk management and inconsistent development of safeguarding plans for residents with known safeguarding risks did not ensure that all residents were adequately protected and safe. The provider had ensured that all staff had attended safeguarding training, and there was a safeguarding policy in place to guide them. All staff were facilitated to attend training on managing responsive behaviours. Records were being maintained that detailed episodes of residents' responsive behaviours and were being recognised, reported and managed as potential safeguarding risks and were effectively managed.

Residents' communication needs were individually assessed, and where residents needed additional support, person-centred care plans were in place. Communication tools and equipment were made available to them that were tailored to their individual needs.

Residents' safeguarding needs were considered in the centre premises provided. Access into the premises was controlled by staff to ensure residents' safety. The layout of residents' bedrooms and communal accommodation ensure their safe access and that restrictions in the residents' lived environment were minimised and appropriately risk assessed. However, the dining facilities provided in Dr McGarry unit did not ensure residents had adequate dining facilities in accordance with their preferences and the centre's statement of purpose.

Residents who were predisposed to experiencing intermittent episodes of responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were provided with appropriate care and supports

Regulation 10: Communication difficulties

Each resident's communication needs were regularly assessed, and a person-centred care plan was developed to guide staff on the supports needed by residents to communicate effectively. Clear signage, assistive equipment, and tools were available to support residents with meeting their communication needs. Staff ensured that individual residents had person-centred communication procedures and tools developed for them and that assistive communication equipment to support their needs was in use and kept within their easy reach to ensure their communication needs were effectively met at all times.

Judgment: Compliant

Regulation 12: Personal possessions

The provider ensured each resident had adequate storage space for their belongings and could access and maintain control of their personal possessions and clothing in their wardrobes, and in the bedside lockers by their bedsides as they wished. Additional storage was provided for individual residents in their bedrooms as necessary.

Residents' personal clothing was laundered in the designated centre's laundry as needed, and their clothing was returned to them without any reported delays.

Judgment: Compliant

Regulation 17: Premises

The provider ensured that the premises were appropriate to the number and needs of the residents living in the centre, and were mostly in accordance with Schedule 6 of the regulations and in line with the centre's stated purpose, with the exception of the following;

- Provision of only one dining table in the sitting/dining room in Dr McGarry unit did not ensure that residents could eat their meals at a dining table, as they wished. This finding was negatively impacting on residents' comfort, dining experience and choice.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

While residents were provided with adequate quantities of food and fluids to meet their needs, not all residents were afforded a choice to sit at a dining table to eat their meals at mealtimes in the Dr. McGarry unit. Although two communal areas were available in this unit, the larger communal room was used as a sitting-dining room, and only one table was available, which did not have sufficient space to accommodate the 12 residents in this unit, a number of whom used assistive wheelchairs.

Judgment: Compliant

Regulation 26: Risk management

The provider ensured that a centre-specific risk management policy was available to staff, and although addressed in separate individual policies, the risk management policy did not set out the measures and actions in place to control the following risks, risk of abuse, unexplained absence of a resident, accidental injury to residents, staff and visitors, aggression and violence, self-harm and infectious diseases.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed the care documentation for a number of residents, and found that the information in residents' care plans was mostly person-centred regarding the care and support each resident needed from staff to meet their assessed needs. However, actions were necessary regarding the assessment of residents' social activity needs to ensure their individual capabilities were adequately assessed to ensure that they were provided with opportunities to participate in social activities that suited their needs, and that supported them with living their best lives. This was evidenced by the following findings;

- Although residents' past interests were assessed, their capacity to participate in the various social activities available was not adequately assessed to inform the tailoring of an individual and meaningful programme of social activities to meet their needs. As a result, these residents' social care plans did not describe a person-centred social activity programme that supported them to participate in activities that suited their needs and met their individual preferences. Furthermore, many of the care records of the social activities that residents participated in did not reference that residents were provided with opportunities to participate in the social activities, they preferred and described in their care plans.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Residents experiencing episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were appropriately supported to ensure both their and other residents' safety. The information in residents behaviour support care plans was sufficiently detailed to guide staff on person-centred care and supports they must provide to meet these residents' needs.

The person in charge and staff were actively promoting a minimal restraint environment. Any restrictions in place were implemented following a trial of less restrictive alternatives, and were informed by appropriate assessments, and regular review.

Judgment: Compliant

Regulation 8: Protection

Although the provider had a number of measures in place to safeguard residents, the measures and actions put in place to safeguard residents involved in peer-to-peer safeguarding incidents needed further improvement actions. For example, safeguarding plans were not developed for residents who experienced responsive behaviours that posed risks to their, and other residents' safety in the Monsignor Young dementia-specific unit. As a number of the staff who carried out enhanced supervision for individual residents were frequently agency staff, there was a risk that pertinent information regarding the actions they should take to safeguard these and other residents would not be effectively communicated to them.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider did not ensure that residents living in the Monsignor Young unit were provided with adequate opportunities to participate in meaningful social activities in line with their individual preferences and capacities. This was evidenced by the following findings;

- The inspector observed that the social activity programme available for residents was limited, particularly in the Monsignor Young unit, where only limited social activities were available in the communal sitting room for a small number of residents. The inspector's observations of the records for two residents receiving enhanced one-to-one care by two staff at all times of the day and night did not provide assurances that these residents' social care needs were considered.

Residents in Dr McGarry unit were not offered a choice and were not adequately supported to eat their meals with other residents at a dining table, as they wished.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Patrick's Community Hospital OSV-0000661

Inspection ID: MON-0047340

Date of inspection: 03/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

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

Outline how you are going to come into compliance with Regulation 15: Staffing:
To ensure compliance with Regulation 15(1) the Registered Provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned. Compliance will be met by the following:

• The Person Participating in Management and Person in Charge have conducted a review of staff training requirements on the 10/02/2026 to ensure that staff possess the appropriate skills to deliver social activities that meet the diverse needs of residents, including residents with complex medical and social care needs, inclusive of residents who prefer to spend significant time in their bedrooms. Following this review based on a recognized staffing tool the Registered Provider is satisfied that the staffing levels adequately support the needs of residents living in the center.
• The Person Participating in Management and the Person in Charge have conducted a review of staffing level and skill mix of the designated centre on the 10/02/2026. The Person Participating in Management and Person in Charge will continue to monitor staffing, resources and the supervision of residents on an ongoing basis to ensure that the services provided are safe and meet the assessed needs of all residents within the centre.
• The Person in Charge has liaised with the local CNME and appropriate service providers to facilitate relevant training to support staff in the provision of social activities. This training will equip staff with the required skills to effectively meet the varied needs and preferences of all residents. Training has commenced for nominated care staff on the 14/04/2026 for CarePals and Exercise Instruction with further programme dates scheduled to include National 2 day programme on Enhancing and enabling well-being for the Person Living with Dementia.
• The Person in Charge and the Person Participating in Management have conducted a review of the schedule of tasks and staff members assigned to residents requiring enhanced care supervision on the 10/02/2026 to ensure meaningful engagement and facilitation of social activities. This will be reviewed on an ongoing basis by the person in

Charge to ensure adequate oversight and supervision.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
To ensure Compliance with Regulation 16 (1)(a), The Person in Charge shall ensure that staff have access to appropriate training are adequately supervised To ensure Compliance with Regulation 16 (1)(b) The person in charge shall ensure that staff are appropriately supervised.: Compliance will be met by the following:

• Regulation 16: Training and Staff Development

To ensure Compliance with Regulation 16 (1)(a), The Person in Charge shall ensure that staff have access to appropriate training are adequately supervised To ensure Compliance with Regulation 16 (1)(b) The person in charge shall ensure that staff are appropriately supervised.: Compliance will be met by the following:

• The Person in Charge and the Person Participating in Management, have completed a review of staff roles and responsibilities within the designated centre on the 10/02/2026. As part of this review, nominated staff are allocated daily to support residents who express a preference or due to clinical need and wish to remain in their bedrooms and those requiring enhanced supervision, to ensure they are provided with appropriate opportunities for meaningful social engagement. This is kept under ongoing review and is determined by each resident's individual will and preference.
• Training in meaningful activities (PAL) assessment is scheduled to commence on the 20/04/2026 with Practice Development coordinator. Training has commenced for nominated care staff on the 14/04/2026 for CarePals and Exercise Instruction with further programme dates scheduled to include National 2 day programme on Enhancing and enabling well-being for the Person Living with Dementia.
• On the 14/02/2026 the Person in Charge together with the Clinical Nurse managers have developed a person centred social care plan for each resident that details a programme of activities tailored in line with their preferences and abilities to ensure staff can support each resident to participate in the social activity programme. This is communicated to all care staff.
• The Person Participating in Management and the Person in Charge have conducted a review of staffing level and skill mix of the designated centre on the 10/02/2026. The Person Participating in Management and Person in Charge will continue to monitor staffing, resources and the supervision of residents on an ongoing basis to ensure that the services provided are safe and meet the assessed needs of all residents within the centre. This will continue to form part of the senior management governance meetings and compliance visits in place within the designated centre.

• The Clinical Nurse Managers or delegated Staff Nurse in charge will provide oversight and supervision to staff on the unit daily.
• The Person in Charge or delegate conducts daily walk around to all units and attends unit meetings to provide consistent support to all staff in their roles, ensuring high standards of care and engagement are maintained.
• The Person in Charge or delegate will continue to review staffing daily to ensure appropriate skill mix across all units in the designated centre to meet the social care needs of the residents.
• The Person in Charge has liaised with the local CNME and appropriate service providers to facilitate relevant training to support staff in the provision of social activities. This training will equip staff with the required skills to effectively meet the varied needs and preferences of all residents. Training has commenced for nominated care staff on the 14/04/2026 for CarePals and Exercise Instruction with further programme dates scheduled to include National 2 day programme on Enhancing and enabling well-being for the Person Living with Dementia.
• The Person in Charge has circulated a training needs analysis to all staff on the 10/04/2026 which will support the achievement of staff professional development and ensuring appropriate training is provided to staff to enhance the standard of care provided to residents.
• The Person in Charge has completed a review of all safeguarding documentation on the 17/02/2026 to ensure identified safeguarding risks are identified and effectively communicated to all staff and that a Behavioural Support plan is in place to mitigate against safeguarding incidents.
• The Person in charge ensures Staff allocated to enhanced supervision of residents are rotated throughout the day to promote residents' independence, autonomy and to ensure meaningful engagement and facilitation of social activities.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure Compliance with Regulation 23(a) Governance and Management the Person Participating in Management shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose: To ensure Compliance with Regulation 23(c) Governance and Management the Person Participating in Management shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Compliance will be met by the following:

• The Person Participating in Management and Person in Charge have completed a comprehensive review on the 10/02/2026 of resources within the designated centre, including staffing levels, skill mix, equipment, and facilities, to ensure compliance with

residents' assessed need.
• The Person in Charge or delegate reviews staffing levels and skill mix daily to ensure there are always adequate numbers of appropriately qualified staff on duty to meet the assessed care needs of residents. Within the designated centre, a clear governance structure is established, outlining roles, responsibilities, and lines of accountability within the centre. This ensures effective oversight and decision-making.
• The Person in Charge has completed a review of all safeguarding documentation on the 17/02/2026 to ensure identified safeguarding risks are identified and effectively communicated to all staff and that a Behavioural Support plan is in place to mitigate against safeguarding incidents. The person in charge is assured that the necessary safeguarding measures are in place in the designated centre.
• The Person in Charge has conducted a review of the dining room in Dr McGarry unit on the 06/02/2026, with additional dining furniture installed and the dining room reconfigured to enhance the environment and meet the needs of all residents.
• The Person Participating in Management and Person in Charge have reviewed the auditing processes on the 16/02/2026 to ensure the residents care documentation is completed to the required standard inclusive of resident's capacity to participate in social activities and safeguarding plans, with timebound quality improvement plans developed and actioned.
• The Person Participating in Management and Person in Charge have reviewed the risk management system on the 26/02/2026 to ensure that risks are identified, assessed, and appropriately controlled, with the Risk Management policy updated to outline the measures and control actions in place for safeguarding against abuse, responding to the unexpected absence of any resident, preventing accidental injury to residents, visitors, and staff, and managing risks associated with aggression, violence, and self-harm.
• The Person Participating in Management and Person in Charge have conducted a review of staff training requirements on the 10/02/2026 to ensure that staff possess the appropriate skills to deliver social activities that meet the diverse needs of residents, including residents with complex medical and social care needs, inclusive of residents who prefer to spend significant time in their bedroom and residents with dementia. Following this review training and supports have been identified to enable staff to support residents in a more meaningful and person-centered way.
• The Person in Charge regularly seeks feedback from residents, families, and staff (including surveys and residents' forum meetings) which will be utilised to inform future service improvements and delivery.
• The Person in Charge and Clinical Nurse Managers have reviewed residents' meaningful activity documentation on the 14/02/2026 to ensure daily records of activities in line with residents' individual preference and capacities, opportunities provided, residents' participation and level of engagement for residents. This is reviewed daily by Clinical Nurse Managers and Staff nurses to ensure appropriate meaningful activity provision for all residents, inclusive of residents with dementia.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

To ensure compliance with Regulation 17(1): Premises: The Person Participating in Management shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3. To ensure compliance with Regulation 17(2): Premises: The Person Participating in Management 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 Compliance will be met by the following:

• The Person in Charge and the Person Participating in Management, completed a review and reconfiguration of the dining facilities and additional dining furniture installed to ensure that all residents are provided with choice and appropriate support to dine at a table with others or alone, in accordance with their individual preferences.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
To ensure compliance with Regulation 26(1)(c)(i) The Person Participating in Management shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse. To ensure compliance with Regulation 26(1)(c)(ii) The Person Participating in Management shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident. To ensure compliance with Regulation 26(1)(c)(iii) The Person Participating in Management shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff. To ensure compliance with Regulation 26(1)(c)(iv) The Person Participating in Management shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence. To ensure compliance with Regulation 26(1)(c)(v) The Person Participating in Management shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.

• The Person Participating in Management and Person in Charge have reviewed and updated the risk management system on the 26/02/2026 to ensure that risks are identified, assessed, and appropriately controlled, with the Risk Management policy updated to outline the measures and control actions in place for safeguarding against abuse, responding to the unexpected absence of any resident, preventing accidental injury to residents, visitors, and staff, and managing risks associated with aggression,

violence, and self-harm.

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:
To ensure compliance with Regulation 5(3) The Person Participating in Management will ensure that a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned. Compliance will be met by the following:

• The Person in Charge has completed a review of all safeguarding documentation on the 17/02/2026 to ensure identified safeguarding risks are identified and effectively communicated to all staff and that a Behavioural Support plan is in place to mitigate against safeguarding incidents.
• The Person in Charge has completed a review of resident's social care assessments to ensure an evaluation of their capacity to participate in activities is included. Care plans have been updated on the 20/02/2026 to reflect individualised, person-centred activity programmes based on each resident's assessed needs and preferences.
• The Person in Charge and Clinical Nurse Managers have reviewed residents' meaningful activity documentation on the 14/02/2026 to ensure daily records of activities and opportunities provided, residents' participation and level of engagement for residents. This is reviewed daily by Clinical Nurse Managers and Staff nurses to ensure appropriate meaningful activity provision.
• Training in meaningful activities (PAL) assessment is scheduled to commence on the 20/04/2026 with Practice Development coordinator which will further enhance the assessment of residents with regard to the provision of meaningful activities.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance with Regulation 8(1). The Person Participating in Management shall take all reasonable measures to protect residents from abuse. Compliance will be met by the following:

• The Person in Charge will ensure that all residents who are admitted or present with

responsive behaviours will have an individualised safeguarding plan and behavioural support plan in place. This will include a comprehensive risk assessment, identification of triggers, and clear guidance for staff on appropriate interventions to ensure residents protected. This will be communicated to all staff.
• The Person in Charge and the Person Participating in Management have conducted a review of the documentation on the 16/02/2026 in relation to resident's care plans to ensure all documentation is reflective of resident's status.
• The Person in Charge with the Clinical Nurse Manager will ensure that all staff, inclusive of agency staff, attend a structured handover and safety pause twice daily. This includes a specific safeguarding briefing, with clear communication of any risks, concerns, or changes in residents' needs. A written handover sheet supports consistent and effective information sharing.
• The Person in Charge has reviewed the training log to ensure all staff within the designated centre have completed the mandatory safeguarding training.
• The Person in Charge promotes a culture of openness and safeguarding awareness, ensuring that all concerns are reported, documented, and responded to promptly in line with safeguarding policies. Incidents and allegations of abuse will be appropriately managed, recorded, investigated, and reviewed to identify learning and prevent recurrence.
• The Person in Charge will oversee that residents safeguarding plans and supervision practices will be formally audited every three months ensuring they are effective, up to date, and consistently implemented in practice.
• The Person in Charge and the Person Participating in Management have conducted a review of the schedule of tasks on the 10/02/2026 and staff members assigned to residents requiring enhanced care supervision to ensure meaningful engagement and facilitation of social activities.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Compliance will be met by the following:

• The Person in Charge and the Person Participating in Management have conducted a review of the schedule of tasks on the 10/02/2026 and staff members assigned to residents requiring enhanced care supervision to ensure meaningful engagement and facilitation of social activities.
• The Person in Charge and the Person Participating in Management commenced a comprehensive review of all social activities on the 10/02/2026. This review included findings from the Residents' Satisfaction Survey 2025 and a bespoke activities questionnaire which was completed on the 24/02/2026. This was communicated to all Clinical Nurse Managers by the Person in Charge on the 27/02/2026 to further enhance residents' social activity provision.

• The Person in Charge and Clinical Nurse Managers have reviewed residents' meaningful activity documentation on the 14/02/2026 to ensure daily records of activities in line with residents' individual preference and capacities, opportunities provided, residents' participation and level of engagement for residents. This is reviewed daily by Clinical Nurse Managers and Staff nurses to ensure appropriate meaningful activity provision for all residents, inclusive of residents with dementia.
• An activity provision sub-group has been developed as part of Residents Rights committee to explore alternative activities to further enhance of the Quality of Life of residents' with regards for their level of engagement.
• The Person in Charge has completed a review of the structured activities programme operational seven days per week on the 20/02/2026, with designated staff assigned to support residents in participating in activities aligned with their needs and preferences ensuring access to both group and one-to-one activities, including activities within and outside the centre Residents are supported and encouraged to integrate into the local community on an individual basis. An intergenerational initiative with local schools is in place, supporting residents to maintain connections with the community.
• The Person in Charge is actively involved in a Community Linkage Programme, which supports residents in accessing a wider range of community-based activities and services, and facilitates community involvement within the centre. This includes a variety of Musical, Sporting and Arts activities.
• The activities programme will remain a standing agenda item at residents' forum meetings to ensure continuous review and inclusion of resident feedback.
• The Person in Charge, in conjunction with the Person Participating in Management on the 06/02/2026 has completed a review and reconfiguration of the dining facilities to ensure that all residents are provided with choice and appropriate support to dine at a table with others or alone, in accordance with their individual preferences and additional dining furniture installed.
• The Person in Charge or delegate will continue to review staffing daily to ensure appropriate skill mix across all units in the designated centre to meet the social care needs of the residents and support meaningful engagement in activities.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/08/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/08/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/05/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	06/02/2026

	provide premises which conform to the matters set out in Schedule 6.			
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	30/06/2026
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	26/02/2026
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the unexplained absence of any resident.	Substantially Compliant	Yellow	26/02/2026
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental	Substantially Compliant	Yellow	26/02/2026

	injury to residents, visitors or staff.			
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Substantially Compliant	Yellow	31/03/2026
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	31/03/2026
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	30/06/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later	Substantially Compliant	Yellow	30/05/2026

	than 48 hours after that resident's admission to the designated centre concerned.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/05/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/03/2026
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.	Not Compliant	Orange	31/03/2026