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:	Unit 1 St Stephen's Hospital
Name of provider:	Health Service Executive
Address of centre:	St Stephens Hospital, Sarsfield Court, Glanmire, Cork
Type of inspection:	Unannounced
Date of inspection:	30 September 2025
Centre ID:	OSV-0000715
Fieldwork ID:	MON-0048452

About the designated centre

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

Unit 1 is a dementia specific unit situated within the 117 acres of grounds at St Stephen's Hospital, Sarsfield's Court, Glanmire, Co Cork. It is situated approximately two kilometres from Glanmire village and seven kilometres from Cork city. It is a single storey detached building and is registered to accommodate 16 residents. Residents' accommodation comprises of one single bedroom, and the rest of bedrooms are three-bedded rooms. Assisted showers toilets and bathrooms are across the corridor. Communal space includes a dining room and sitting room and a sensory room. Residents have access to an enclosed garden with panoramic views of the valley and countryside. All bedrooms open onto a veranda. The centre provides residential care predominately to people over the age of 65 but also caters for younger people over the age of 18, long-term residents and palliative care to older people with dementia. The centre provides 24-hour nursing care and medical care is available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 30 September 2025	09:25hrs to 15:30hrs	Ella Ferriter	Lead

What residents told us and what inspectors observed

There was a calm and relaxed atmosphere evident throughout the day in Unit 1, St Stephens Hospital. The inspector could see that management and staff knew the seven residents living in the centre well and were familiar with each residents' daily routine and preferences. All residents in the centre were living with a diagnosis of dementia or cognitive impairment and were unable to fully express their opinions on the quality of life in the centre. These residents appeared comfortable and content. Staff were observed to be kind and compassionate when providing care and support in a respectful and unhurried manner. The inspector did not have the opportunity to meet with any of the residents' relatives, as they were not visiting on the day.

This was a one-day unannounced inspection, with a specific focus on the centre's approach to and practices, in relation to safeguarding. Unit 1 St Stephen's Hospital is single storey designated centre for older people, specifically caring for residents with dementia. It is registered to provide care to 16 residents and occupancy over the past few years was approximately five to seven residents. It is situated on an extensive 117 acre site which is co-located on a large campus with other individual units. This service is collectively known as Sarsfield Court, which specialises in Mental Health Services. The centre is located close to the village of Glanmire, seven kilometres from Cork city.

Bedroom accommodation in the centre is situated along one long corridor, visible from inside the front door of the centre. Specifically, it comprises of five three bedded rooms and one single bedroom. The inspector observed that a couple of residents had personal belonging around their beds such as family photographs. However, the majority of bedrooms lacked personalisation and decor and were more reflective of a hospital environment. Although it was evident that some work had been done over the past few years, such as the addition of furniture and some pictures, with the attempt at making the centre more homely, further action was required as actioned under Regulation 17.

Residents shared bathroom and shower facilities, which were all situated on the main corridor. Bedrooms were observed to be visibly clean and there was access to the external garden from these bedrooms. There was also access to the secure garden via a door in the sitting room. However, the inspector observed that access to these garden areas was limited for residents and doors remained locked at all times. Discussions with staff indicated that residents had to request to access these areas for their safety. The main front door of the centre was controlled by a keypad locking system. Residents did not have the code for this door, and the reason for this was based on a validated risk assessment of their safety.

Communal spaces within the centre included a sitting room, dining room and a sensory room. The sitting room had a fire place, television and some old memorabilia and was seen to be a comfortable place for residents to relax. The inspector observed residents in various areas of the centre throughout the

inspection day. For example, a couple of residents enjoyed spending time on arm chairs inside the front door, and others relaxed in the sitting room or walked around the centre accompanied by staff. Communal areas were observed to be supervised at all times throughout the day. Although staff reported that residents enjoyed the outdoor areas, as there was rain on the day, residents were not seen outdoors. The centre had a resident cat whose home was in the garden.

Main meals were delivered to the centre from the central kitchen in a heated bain-marie, ensuring that all food was warm and appetising. Regular snacks and drinks were offered to residents between meals. Each unit had a kitchenette and residents could access a range of different foods and drinks when the main kitchen was closed. During meal times, staff were observed to be interacting with residents in a friendly manner. Five residents were observed to eat in the dining room, however, the inspector observed that all residents were seated at different tables and therefore there were limited opportunities for social engagement and a normal dining experience. From discussions with staff there was no apparent reason for this practice.

The inspector observed that residents were receiving good care and attention throughout the day which was appropriate to the residents' individual needs. Staff who spoke with the inspector were very familiar with the residents' lives, past history, hobbies, and their preferred daily routines, along with the level of support needs that they required. Staff were observed taking time to sit with residents throughout the day. Two residents were observed having their hair and nails done which they enjoyed, while others were read the daily newspapers, which staff discussed with them. One resident was visited by a nurse therapist for one to one massage and another attended day care services on the campus.

The following sections of this report detail the findings with regard to the capacity and capability of the provider and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced inspection which focused on adult safeguarding and specifically reviewed the arrangements the provider had in place to safeguard and protect residents from all forms of abuse and promote their human rights. The inspector also followed up on the findings of the previous inspection of April 2025, which found that significant action was required pertaining to residents rights, safeguarding and the governance and management of the centre. Findings of this inspection were that the provider had taken the necessary action and implemented their compliance plan, to ensure that residents were safeguarded. However, some further action was required in relation to written policies and procedures, training, the management of responsive behaviours, residents rights and the premises. These findings will be further detailed under the relevant regulations of this report.

The registered provider of this centre is the Health Service Executive (HSE). As outlined in the centres statement of purpose the centre provides care for residents with a cognitive impairment. The last inspection of this centre found that there was ambiguity with regards to senior management roles and responsibilities for the service and who the staff in the centre reported to in the event of an emergency or in the absence of the person in charge. Following this inspection the provider was requested to attend a cautionary meeting to discuss concerns with regards to the management of safeguarding incidents within the centre, the governance and management arrangements in the centre and absence of a social programme for residents. Findings of this inspection were that the provider had established more effective systems and processes, to ensure residents were safeguarded and protected from abuse and had strengthened their governance and reporting arrangements, which were now more clearly defined and established. The person in charge reported to a general manager in the HSE, who the inspector was informed was available for consultation daily. They were a named person participating in management (PPIM) on the centres registration. There was evidence that monthly meetings took place to discuss the operational management of the service. For clinical support there was also support provided by and Area Director of Nursing Mental Health and a Clinical Director, who attended the centre at a minimum of once per week.

The person in charge worked full time in the centre and was supported by a clinical nurse manager, a team of nurses and healthcare assistants, multi-task attendants, and catering staff. Cleaning staff were provided by an external agency and attended the centre seven days per week and there were also administration and maintenance staff available on the main campus. There were deputising arrangements in place for the person in charge, to ensure that the centre was appropriately managed in their absence. On the day of this inspection there were adequate staffing levels for the size and layout of the centre to meet the assessed need of residents. However, the centre was the using agency staff to fill the desired roster on a weekly basis. Action was required to ensure that there were arrangements in place to recruit staff to operate the service and to ensure that that continuity of care was promoted, which is actioned under Regulation 23.

The person in charge was the designated safeguarding officer and clearly promoted safeguarding in the centre.The provider had enhanced their management systems to ensure that the services approach to safeguarding was appropriate, consistent and effectively monitored. Where safeguarding concerns had been identified the inspector found that these were being investigated by the provider and the safeguarding plan was being adhered to. However, as found on the previous inspection the safeguarding policy was generic and reflected the national HSE system. Therefore, this did not provide specific guidance for staff on how to appropriately respond to an incident within the centre. Action was also required to ensure that when a safeguarding incident occurred that it was reported to all relevant authorities. This finding is actioned under Regulation 23.

There was a schedule of ongoing safeguarding training for staff and staff spoken with demonstrated an understanding of the importance of reporting and responding to safeguarding concerns. Mandatory training included the management of

restrictive practices, and the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Discussions with the management team indicated that training had been attended by some staff in promoting a human rights based approaches to care in 2021 and there were plans to reintroduce this training in the coming months. However, staff allocated to work in the centre from other units on the campus did not attend training on restrictive practices and responsive behaviors, which is actioned under Regulation 16.

In response to the findings of the previous inspection staff supervision had been enhanced to support the safeguarding of residents and this ensured that safeguarding plans were adhered to. The inspector reviewed a sample of staff personnel files to review the provider's recruitment practices to safeguard residents from abuse. Records contained the necessary information, as required by Schedule 2 of the regulations, including Garda Síochána (police) vetting disclosures, employment history and references.

The person in charge had consulted with residents and their families and sought their feedback on the service provided. This feedback was incorporated into the annual review of the quality and safety of care delivered to residents in 2024. There was evidence of good management systems in place such as daily handovers, meetings, the tracking clinical data and audits.

Regulation 15: Staffing

There were adequate staffing levels for the size and layout of the centre to meet the assessed need of residents on the day of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff working in the centre seconded from the Mental health facilities on the shared campus, had not undertake training in the management of responsive behaviors and restraint. This training is required to ensure that all staff have the required to knowledge to care for residents appropriately and understand a social model of care.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems required review to ensure that the service provided was safe, appropriate, and consistently monitored, evidenced by the following findings:

- Although safeguarding concerns were taken seriously, and were being investigated by the provider, the inspector was not assured they they were reported to the relevant authorities, such as An Garda Siochana, in line with legislation and as per national policy.
- There was a lack of oversight of policies and procedures as outlined under Regulation 4.
- The oversight of staffing in the centre was not sufficiently robust. On the day of this inspection there were two Health Care Assistant vacancies and one Registered Nurse on extended leave. These positions had not been filled. Therefore, the inspector was not assured that there were appropriate arrangements in place to promote staff retention and ensure continuity of care. This was of particular significance in this service as on review of residents care plan documentation it was evident that some residents required to be cared for by staff which they were familiar with.
- On review of the risk documentation it was evident that risks were not being assessed in line with the centres risk assessment policy. Specifically, the risk matrix was being used incorrectly, and did not reflect the likelihood and severity of potential harm. Therefore, this did not provide assurance that there was appropriate oversight of risk within the centre.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Action was required to ensure that the safeguarding policy was centre specific and available to guide staff. This was also a finding of the previous inspection and had not been actioned by the registered provider. Additionally, some policies required as per Schedule 5 were found to be expired: For example:

- Two policies in relation to medicines had expired in October 2024 and March 2025.
- The policy in relation to the monitoring of nutritional intake had expired in January 2025.
- The policy on recruitment of staff had expired in March 2025.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that residents were in receipt of a good standard of care and support from kind staff and were safeguarded from abuse in the centre. Staff treated residents with dignity and respect and knew residents well. Some actions were required pertaining to the premises, the management responsive behaviours and residents rights which will be further detailed in this section of the report.

There had been two admissions to the centre in the past six months. It was evident that comprehensive, validated assessments were completed for these residents, and these informed each individual care plan. The content in care plans captured personal details, individual needs and preferences. From a safeguarding perspective, residents were assessed for any existing safeguarding concerns prior to admission, and thereafter on a regular basis. There was evidence in individual care plans of potential or actual safeguarding risks, and details on how these were managed.

The service strived to protect each resident from the risk of harm and to promote their safety and welfare. Discussions with the person in charge indicated that there was a clear process to escalate any safeguarding incidents to senior management and to the HSE safeguarding team. This ensured that the centre's approach to safeguarding was appropriate, consistent, and effectively monitored. However, action was required to ensure care plans could clearly direct staff on caring for residents with responsive behaviours and appropriate risk assessments were carried out for residents using restraint. These and other findings are actioned under Regulation 7.

The centre had access to independent advocacy services and discussions with the management team indicated that residents may also benefit from access to decision support services, which could be accessed. Residents were supported to go on days out of the centre with friends and family and this was encouraged. There was a weekly schedule of activities in place which residents could attend and it was evident staff incorporated a social model of care, carrying out one to one activities with residents while considering their preferences and abilities. Residents had good access to a range of media which included newspapers and radios.

Regulation 10: Communication difficulties

All residents had communication care plans which were developed based on the residents' know communication difficulties, for example poor eyesight or hearing, impaired speech or their cognitive impairment. The inspector observed staff communicating with residents in an appropriate manner, which ensured that the residents were content throughout the day. Where safeguarding concerns were being investigated families were being kept fully informed of all matters.

Judgment: Compliant

Regulation 17: Premises

Areas to be addressed pertaining to the premises to ensure it complied with Schedule 6 of the regulations included the following:

- There was very limited decor in some areas of the centre, such as the corridor, dining room and residents bedrooms. This made these areas appear clinical as opposed to homely.
- The televisions in multi-occupancy bedrooms were situated above the door frame, therefore, they were difficult to view for residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The provider had arrangements in place to meet the safeguarding needs of each resident. Where safeguarding risks had been identified they were being managed as part of the ongoing assessment and care planning process. Residents where possible, and their families were supported to make their own decisions in relation to their care plan development and review.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The centre did not fully meet the requirements of this Regulation as the inspector noted the following:

- The inspector found that doors to the gardens were kept locked. This was found to be restrictive. This was not identified as a restraint within the centre and was not documented on the centres risk register. This was also a finding on the previous inspection.
- Care plans for residents who presented with responsive behaviours did not always outline de-escalation techniques, and ways to effectively respond to behaviours.
- Where restraint was in use there was not always evidence that this was appropriate. For example; a resident had a sensor mat under their chair when they were using communal spaces however this was not required as per their most recent risk assessment. Another resident was allocated bed rails when

their risk assessment indicated they should not be used, due to their medical history.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to safeguard and protect residents. Staff spoken with showed strong awareness of safeguarding, and were encouraged to be open and accountable. All staff had completed safeguarding of vulnerable persons training.

Judgment: Compliant

Regulation 9: Residents' rights

Some actions were required to ensure residents rights were upheld in the centre, evidenced by the following findings:

- There was some signage on display in the centre which was related to residents personal information. This did not ensure their privacy was respected.
- Residents did not have the opportunity to have a social dining experience, due to the fact that they were separated in the dining room at different tables.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Unit 1 St Stephen's Hospital OSV-0000715

Inspection ID: MON-0048452

Date of inspection: 30/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training records for the Therapy Nurse and the Occupational Therapist from Valley View have been requested from their respective line managers. Safeguarding training has been completed by staff. Training in restrictive practice has been organised for 16th December in Unit 1 which will be attended by the therapy nurse and OT.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To strengthen safeguarding practices and enhance the overall safety of residents, we have developed a comprehensive local Safeguarding Policy. This policy clearly outlines the responsibilities of all staff members in the event of a safeguarding concern and is fully aligned with HIQA and HSE standards. The policy sets out clear procedures for the identification, reporting, and management of safeguarding issues, and includes explicit guidance regarding the duty of the Person in Charge (PIC) to notify An Garda Síochána without delay where a concern constitutes a potential criminal offence. We have communicated the policy to all staff and will ensure its implementation through	

training, supervision, and ongoing review.
All policies and procedures will be updated by 31/12/25.

3 Staff nurse posts and 2 HCA posts have been approved for filling. All HR documentation has been completed up-loaded to the Gateway for recruitment from the Older Persons panel.

Care plan risk assessments have been up-dated.

Regulation 4: Written policies and procedures	Not Compliant

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

The Medicines management policy in now updated. The second policy on out of hours access to pharmacy is no longer required as this is now incorporated in the new medicines management policy in section 2.8.

The Nutritional Intake policy has been updated.

The staffing policy is now up-dated.

All remaining polices are presently being reviewed and up-dated.

Regulation 17: Premises	Substantially Compliant

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

Homely items will be purchased for the dining room. Funding has been requested for same.

Request has been placed in the arantico maintenance system to relocate televisions. This work should be completed within 2 weeks.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

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

The access code for the garden door is now placed over the key pad in order that residents and visitors who wish to access the garden can do so freely.

Care plans have been up-dated with personalized de-escalation pointers for each resident.

Care plans have been reviewed.

The sensor mat has been removed from the resident in the main communal area, and side rails are only used for those resident's risk assessed to require them.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Signage with personal information has been removed.

The dining room experience has been reviewed to encourage social interaction between residents.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	16/12/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/12/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2026
Regulation 04(3)	The registered provider shall review the policies	Not Compliant	Orange	31/12/2025

	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.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	01/12/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	31/10/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/10/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is	Substantially Compliant	Yellow	31/10/2025

	reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			