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:	Elmhurst Nursing Home
Name of provider:	Sparantus Limited
Address of centre:	Hampstead Avenue, Ballymun Road, Glasnevin, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	25 May 2026
Centre ID:	OSV-0000134
Fieldwork ID:	MON-0049837

About the designated centre

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

Elmhurst Nursing Home is located in Glasnevin, Dublin 9. The centre can accommodate 44 residents, both male and female over the age of 18. The centre provides long-term care to older persons, some of whom have a cognitive impairment. Elmhurst Nursing Home is a single-storey building comprising of two units. There are a range of communal areas available to residents, including an activities room, two dining rooms and an oratory. Elmhurst Nursing Home provides long-term care to older persons, and is committed to providing the highest standard of care and support to all residents. Elmhurst Nursing Home cares for residents in an environment appropriate to their needs, where the priority is to preserve their dignity and promote their independence.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	42

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
Monday 25 May 2026	08:30hrs to 16:05hrs	Laurena Guinan	Support

What residents told us and what inspectors observed

Residents living in Elmhurst Nursing Home gave positive feedback on their experience of living in the centre, and praised staff for their kindness. This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector also followed up on the compliance plan from the previous inspection, and unsolicited information received by, and statutory notifications submitted, to the Chief Inspector since the last inspection in May 2025. The inspector conducted a walk around of the centre and met with management personnel. A number of documents were reviewed, and residents, families and staff members were spoken with during the day.

Elmhurst Nursing Home was set in a single storey building in mature grounds. On arrival, there was a reception area where visitors were requested to sign in, and information on the complaints process, advocacy services and fire safety was on display. An activities room, chapel and offices were located in this area. The inspector observed boxes stored on the floor of the activities room and the door to the chapel was propped open by a chair, which did not support good fire safety practices.

Residents' accommodation comprised of single bedrooms and was divided into two units, Elmhurst and Desmond. Each unit had its' own dining and living areas, and there was access to outdoor areas from each unit. There was a smoking area in one of the courtyards that had an ashtray and call-bell, but the fire blanket here was unsecured, partially open and had cobwebs on it. This was brought to the attention of the person in charge who committed to ensuring a suitable fire blanket would be safely stored here. Each unit had its' own storage rooms and nurses' stations. The inspector saw paint tins and painting equipment stored on the floor of one of the store rooms, and both nurses' stations were found unlocked, with medication and residents' files easily accessible, on the morning of the inspection. This was brought to the attention of nursing staff on both occasions, and the nurses' stations were seen to be locked when not in use for the remainder of the day.

The premises were kept clean and tidy internally, and many residents' rooms were personalised with their own belongings such as bedspreads and photos. Residents spoken with said that they were very happy with their rooms, describing them as 'peaceful' and 'nice and bright'. However, some maintenance issues such as worn furniture and stained walls were observed, and windows to the rear of the building were very dirty externally, with some wooden window frames in a bad state of repair.

The inspector observed lunch and breakfast being served, and residents had the choice to dine in their rooms or in one of the dining rooms. Residents said that food was always served hot, and those who had meals in their rooms had them

individually prepared and taken to their room without delay. There was ample staff to assist, and they did so in a respectful manner. Residents told the inspector that there was a good variety of food, and they were offered condiments and a choice of drinks. Fresh water was seen to be delivered to the bedrooms in the morning.

Visitors were seen coming and going during the day, and those spoken with said that staff were always courteous and made them feel welcome. They said that they were kept updated on changes in their loved ones' condition, with one visitor saying they 'couldn't fault anything'. Another visitor said that they had told staff different stories about their loved one's life and interests, and they were happy to see that staff had used that information when caring for the resident.

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

Capacity and capability

There was a stable management structure in place, and the inspector saw many good management systems to monitor and drive quality improvement in the centre. However, greater oversight was required with regards to the completion of the compliance plan from the previous inspection, staff practices, maintenance of the premises, and the submission of notifications.

Sparantus Limited was the registered provider of Elmhurst Nursing Home, and they provided management support in areas such as HR and finance. The Director of Quality and Clinical Governance, who had been appointed by the provider to support the person in charge, was onsite once or twice a week and was present on the day of the inspection. The Chief Executive Officer attended the feedback meeting at the end of the inspection. There was a person in charge who worked full-time in the centre, and they were supported in their role by a Clinical Nurse Specialist and Clinical Nurse Managers. Staff nurses, healthcare assistants, activities coordinators, household, catering and maintenance staff made up the remainder of the staff team in the centre.

The inspector saw a system of audits that showed a high compliance in areas of care plans and end-of-life care, and identified gaps seen on the day of the inspection with regards to the oversight of maintenance issues. As a result of audit findings which identified challenges in co-ordinating the maintenance of the premises, the provider had delegated the oversight of maintenance to the Director of Quality and Clinical Governance in November of last year. There was a system of staff and management meetings that showed good two-way communication in the centre. Staff were made aware of the findings of audits, and were given the opportunity to raise concerns. Meetings and audits had action plans to address issues identified, and named a person responsible for implementing the plan. For

example, a care plan audit identified gaps in the documentation of pressure prevention plans, and an action plan to address this was seen to have been implemented. A family survey had been conducted, and the results of this was on display in the reception area. The response was mostly favourable, although some concerns raised by families did not have an action plan to address them. This was discussed with the Director of Quality and Clinical Governance who acknowledged the oversight and committed to implementing an action plan. Much of the compliance plan from the previous inspection had been completed, although maintenance issues remained outstanding and the residents' guide had not been updated as agreed. The provider had committed to completing fire improvement works in the compliance plan which were to have been completed in March 2026. However, these were not seen to be completed on the day of inspection. The provider had submitted an update on the works completed, and a request to extend the completion date for the final works was being assessed by the Chief Inspector. A meeting was held with volunteers in April, and this outlined their role in the centre, and discussed safeguarding and residents' rights.

The inspector reviewed the training matrix in the centre and found that there were high levels of compliance with mandatory training including safeguarding, manual handling and fire safety training. A member of the nursing management team worked in a supernumerary capacity during the day to provide support to staff, and a clinical nurse manager was available for staff support on night duty. An induction checklist was in place for agency staff, and those spoken with confirmed that they had completed it. They said they were given a handover at the start of their shift, and were aware of reporting procedures in the centre.

The inspector discussed the submission of statutory notifications to the office of the Chief Inspector with the person in charge. One notification had been incorrectly submitted as part of the quarterly returns; however, due to the nature of the incident this was required to be submitted to the Chief Inspector within two days of the event occurring. Two other notifications had been received after the required timeframe had passed. The criteria and timelines for submission of notifications were clarified, and the notifications were correctly submitted retrospectively.

Regulation 16: Training and staff development

Staff had access to training appropriate to their roles and were appropriately supervised.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a valid insurance contract in place.

Judgment: Compliant

Regulation 23: Governance and management

While the management systems ensured that residents were safe, the systems in place had not always ensured that the service provided was effectively monitored. For example:

- Concerns raised by families through a family survey did not have action plans in place to address them.
- The oversight of the maintenance of the premises had not ensured that works committed to in the compliance plan following the previous inspection had been completed within the agreed timeframe. For example; fire works remained outstanding and the residents' guide had not been updated.
- The oversight of the maintenance of the premises had not identified issues such as heavily dirty windows, window frames in a state of disrepair, worn furniture, and stained walls seen on the day of the inspection.
- The oversight of staff practices had not identified inappropriate storage or fire doors propped open, as seen on the day of the inspection.
- The oversight of the submission of notifications had not ensured that the correct criteria was followed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all the notifications as required in the regulations had been submitted to the Chief Inspector. This included:

- One notification which was required to be submitted within two days of the event occurring had incorrectly been included in the quarterly notifications.
- Two notifications had not been received within the correct time frame.

Judgment: Not compliant

Quality and safety

Overall, residents expressed satisfaction with the care provided, and with the responsiveness and kindness of staff. However, deficits in the oversight of care plans, consent for restrictive practices and the maintenance of the premises were seen on the day of the inspection.

The inspector reviewed a sample of care plans with a focus on end-of-life care, managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and the use of restrictive practices. Validated assessment tools were used to develop care plans within 48hrs of admission and these were reviewed every four months, or as required. Care plans were person-centred and clearly directed care in line with the residents' assessed needs and preferences. It was documented in the care plans that they would be reviewed in consultation with the resident or family, however, on review of a family survey, two families reported that they had not been involved in care planning, or were unaware of care plans. This was brought to the attention of the person in charge as no action plan was in place to address these comments.

Residents had good access to appropriate medical and health care. A general practitioner (GP) attended the centre twice weekly and was readily available for out-of-hours cover. Residents had access to a range of health care professionals, including chiropody, tissue viability nurse and psychiatry of later life, and this was evidenced from a review of residents' care records. The residents and visitors who spoke with the inspector were satisfied with the GP service and out-of-hours medical cover.

From a sample of residents' records who had recently passed away, the inspector saw that end-of-life care plans had been developed some time prior to the resident's passing. The care plans were personalised with residents' wishes regarding resuscitation status, transfer to hospital, religious preferences, and persons to contact. These wishes were seen to have been followed for each resident. The family of a resident who had passed away said that they were very happy with the care provided to their loved one. They felt staff communicated well with them, and accommodated them to stay with their relative. Staff displayed a good understanding of caring for a deteriorating resident, including warning signs, escalation pathways, and respecting residents' wishes.

There was a policy on the use of restrictive practices in place. The inspector saw that where restrictive practices were in use, a validated assessment tool had been used, and a care plan developed; however, there was no evidence that consent for the use of the restraint had been obtained from the resident or their family. The restrictive practice was implemented after discussion with the GP and multi-disciplinary team, but the person in charge confirmed that consent was not routinely sought, and they committed to reviewing this. Care plans for residents who displayed responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were personalised with potential triggers for the behaviour and de-escalation techniques for that resident. Some residents had been assessed

as requiring enhanced supervision and they were seen to receive this in line with their care plans. Staff spoken with showed a good understanding of how to manage responsive behaviours, and were knowledgeable of different residents' needs. All staff were trained in restrictive practices and the management of responsive behaviour.

The inspector saw that the centre was kept clean internally. The corridors were kept clear of obstruction and had handrails so residents could move easily around the centre. However, there were areas of wear and tear observed, with some items of furniture worn and chipped, the blinds in one of the dining rooms were unclean, and a chair in one resident's bedroom was badly damaged. There was an area beside a visitors' room where the paintwork was stained, and the inspector observed that the outside of the windows at the rear of the building were heavily soiled. A window cleaner had been engaged to attend the centre the following week, however, this had only been done in response to a complaint raised by a family member. Some of these windows were wood frame and were seen to be in a bad state of repair, with chipped paint and damage to the frames.

The inspector saw many kind and respectful interactions during the day, and residents spoken with said that staff were kind and treated them with respect. There was a calm atmosphere in the centre, and call-bells were responded to promptly. Residents said that when they sought assistance, they received it quickly. Some residents were receiving hand massages and manicures in the morning, and one resident said it was something they really enjoyed. There was a game of bingo in the afternoon, and a number of residents had said they were looking forward to it. Residents also said they enjoyed art and music activities, and told the inspector that staff were always conscious to facilitate them to attend activities. Mass was held twice weekly, and a number of residents said this was very important to them. There was access to TV, radio and newspapers, and residents had been facilitated to vote in the recent by-elections. A record of residents' meetings was seen, and these had action plans to address issues raised by residents. For example, residents had requested a clock with a date display. This had been referred to the occupational therapist, who had placed an order for one which was due to be delivered on 30th May.

Regulation 13: End of life

Residents had end-of-life care plans that detailed their wishes. Those receiving end-of-life care were seen to be afforded appropriate care and comfort. The residents' families were facilitated to be present with them.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured that the premises conformed to the matters set out Schedule 6 as evidenced by:

- Worn and damaged furniture. This is a repeat finding.
- Heavily soiled windows, and window frames in a state of disrepair.
- Area of stained paintwork.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents had regular, comprehensive assessments of their needs, and care plans were developed based on these assessments. The care plans were reviewed at a minimum of four monthly intervals; however, it was unclear whether residents and their families were involved in developing the care plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were seen to be referred to allied health professionals in a timely manner, and their recommendations were seen to be implemented in practice.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff displayed good knowledge and skills to respond to and manage behaviour that challenges. Assessments and care plans to support restrictive practices in use were found to be person-centred; however, consent was not obtained from the resident or their family.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had ensured that residents had adequate facilities and opportunities to engage in activities, communicate freely and exercise their rights. Residents were consulted about and participated in the organisation of the centre.
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	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Elmhurst Nursing Home OSV-0000134

Inspection ID: MON-0049837

Date of inspection: 25/05/2026

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 23: Governance and management	Substantially Compliant

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

Action: At time of inspection there was no formalised actions developed following resident feedback. On the day of inspection, a new element to the 2026 CAPA was added and this now captures the feedback from resident community meetings, resident and family surveys and any feedback arising from an inspection. All previous feedback from Community Meetings are included into the CAPA now to identify trends, and highlight effectiveness of actions taken. New feedback from Community meetings will be included effective immediate. The CAPA, including movement of outstanding action items, is a standing item on the Nursing Home Clinical Governance Committee, and the Executive Management Team meetings for oversight.
Timeframe: Effective from day of inspection with ongoing monitoring.
Responsible persons: Person In Charge; Director of Quality & Clinical Governance

Action: 2025 Corrective Action Plan: The management team within the Elmhurst Nursing Home note the outstanding actions identified on the 2025 corrective Action Plan. There has been ongoing communication with the regulators around the corrective Fire Cavity Barrier works and the organisation has ensured that a programme of fire corrective actions have been undertaken and the risks identified have been reduced from high risk to moderate risk. These works are ongoing, and, as per recent communication, a more detailed plan, including costing, implementation and timebound actions has been sought from specialist experts under development by Head of Facilities & Sustainability.
Following completion of the initial Fire Safety Risk Assessment by an independent Fire Engineering Specialist, a programme of fire safety improvement works was undertaken across the nursing home. The remaining significant items relate to the installation of cavity barriers within the roof voids and the fire protection of the light wells. Due to the technical complexity, specialist nature and significant cost of these works, an extension of time was requested from HIQA to allow for further investigation, project planning, and

procurement.

To provide additional independent assurance, a second Fire Engineering Specialist was commissioned to undertake a detailed review of the outstanding works. This assessment has now been completed and independently verifies the scope of works previously identified. The review also confirms that the works can be undertaken safely while residents remain in situ through appropriate phasing, contractor controls, and project management arrangements, thereby avoiding the need to relocate residents during the project.
The final fire engineering report has now been completed, and the project management team is preparing the detailed specification and tender documentation. The works will be issued to a minimum of two, and where possible three, specialist contractors, with tender returns anticipated by the end of August 2026. Following evaluation of the tenders, the preferred contractor will be appointed, and the implementation programme and project timelines will be finalised.

Timeframe: Given the complexity of the works needed a phased approach is currently under development to ensure resident safety. The intention is to start the works in September 2026 in a phase manner with the works continuing on until an anticipated Mar 27 completion. Phase plan will be fully outlined within the expected documentation and time bound estates works plan.
Responsible persons: Person In Charge; Head of Facilities and Sustainability; Director of Quality & Clinical Governance.

Action: A review of all furniture within the nursing home was completed. Items identified as damaged, defective, or requiring attention were removed from service immediately or referred for repair and maintenance. Regular environmental audits and safety checks by the CNMs and PIC will continue to provide ongoing assurance that the premises are maintained in a safe condition and remain suitable for residents' use, in line with regulatory requirements and best practice. Oversight for maintenance and premise is held by Head of Facilities & Sustainability and a current program of costings and remedial actions is underway as requested by the regulators.
Timeframe: Immediate actions completed. Ongoing monitoring thereafter. Dedicated maintenance team under recruitment with expected completion by 31st October 26.
Responsible persons: CNMs; Person In Charge

Action: External window cleaning has been completed in all areas identified during the inspection and has been incorporated into the Planned Preventive Maintenance (PPM) Programme at an increased frequency. External timber window frames are now included in a scheduled programme of repair and repainting, while internal stained walls are being addressed through the planned maintenance and decoration programme. These works are monitored through the Estates Maintenance Programme, with oversight from the Head of Facilities & Sustainability and the Director of Quality & Clinical Governance, providing assurance that the premises are maintained to a safe, well-presented, and appropriate standard for residents.
Timeframe: Immediate actions completed. Dedicated maintenance team under recruitment with expected completion by 31st October 26.

Responsible persons: CNMs; Person In Charge

Action: Fire safety practices have been reinforced to ensure that fire doors remain closed at all times, unless fitted with an approved hold-open device linked to the fire alarm system and the risks associated with inappropriate storage. Staff have been reminded of the importance of maintaining fire compartmentation and the risks associated with fire doors being propped open, including the potential impact on resident safety and effective fire containment. This has been communicated through staff supervision, safety briefings and unit meetings.
Ongoing oversight is maintained through regular environmental and supervisory rounds undertaken by the PIC and CNMs, with any identified issues addressed promptly.
Timeframe: Implemented on the day of inspection and subject to ongoing monitoring.
Responsible Persons: Person in Charge (PIC); Clinical Nurse Managers (CNMs).

Action: Additional training and development is to be provided to support the CNM's within the Elmhurst Nursing Home to understand the need for timely and correct reporting, discharge their responsibilities and to work alongside the PIC and Quality & Patient Safety Coordinator to ensure reporting is in line with expectation.
The Director of Quality & Clinical Governance will provide an additional level of oversight and will work closely with PIC to ensure the correct notification status.
Timeframe: Training will be completed by 31st July 2026
Responsible Persons: Person in Charge (PIC); Quality & Patient Safety Coordinator

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Action: Additional training and development is being provided to support the CNM's within the Elmhurst Nursing Home to understand the need for timely and correct reporting, discharge their responsibilities and to work alongside the PIC and Quality & Patient Safety Coordinator to ensure reporting is in line with expectation.
The Director of Quality & Clinical Governance will provide an additional level of oversight and will work closely with PIC to ensure the correct notification status.
Timeframe: Training will be completed by 31st July 2026
Responsible Persons: Person in Charge (PIC); Quality & Patient Safety Coordinator

Regulation 17: Premises	Substantially Compliant

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

Actions:
A review of all furniture within the nursing home was completed. Items identified as damaged, defective, or requiring attention were removed from service immediately or referred for repair and maintenance. Regular environmental audits and safety checks by the CNMs and PIC will continue to provide ongoing assurance that the premises are maintained in a safe condition and remain suitable for residents' use, in line with regulatory requirements and best practice.
Oversight for maintenance and premise is held by Head of Facilities & Sustainability and a current program of costings and remedial actions is underway as requested by the regulators.
Timeframe: Immediate actions completed. Completion for remaining actions will be 31st of October 26.
Responsible persons: CNMs; Person In Charge

Action: External window cleaning has been completed in all areas identified during the inspection and has been incorporated into the Planned Preventive Maintenance (PPM) Programme at an increased frequency. External timber window frames are now included in a scheduled programme of repair and repainting, while internal stained walls are being addressed through the planned maintenance and decoration programme. These works are monitored through the Estates Maintenance Programme, with oversight from the Head of Facilities & Sustainability and the Director of Quality & Clinical Governance, providing assurance that the premises are maintained to a safe, well-presented, and appropriate standard for residents.

Timeframe: Immediate actions completed. Completion for remaining actions will be the 31st of October in line with maintenance program.
Responsible persons: CNMs; Person In Charge; Head of Facilities and Sustainability; Director of Quality & Clinical Governance.

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:

Action: Care planning processes have been strengthened to ensure residents, and where appropriate their families or representatives, are consulted and involved in care plan development and review, with evidence of consultation documented in resident records.

A revised care plan audit tool has been introduced and will be evaluated to ensure it identifies gaps in documentation and practice.
Ten residents have commenced the new structured holistic care plan, which will replace the current system of multiple care plans. The pilot will be evaluated and refined prior to full implementation, with centre-wide rollout anticipated to be completed by 31 October 2026.
As part of the trial staff training is being provided on the new care plan format and care planning requirements. Quarterly audits undertaken by the PIC and CNMs will monitor compliance, consistency, and the quality of person-centred care planning.

Timeframe: Immediate actions commenced – trial of 10 residents. Full rollout by 31st October 2026. Ongoing monitoring thereafter.
Responsible persons: CNMs; Person In Charge

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:

Action: In line with Regulation 7(3), the Department of Health's policy Towards a Restraint-Free Environment in Nursing Homes (2011) and HIQA's Guidance on Promoting a Care Environment that is Free from Restrictive Practice (2025), informed consent for the use of restrictive practices will be formally sought, documented and regularly reviewed with the resident and/or their representative, where appropriate. Evidence of consent will be clearly recorded within the resident's care plan and restrictive practice assessment documentation. Where a resident lacks the capacity to provide informed consent and has no representative, the rationale for the restrictive practice, capacity assessment, consideration of alternative measures, multidisciplinary decision-making process and ongoing reviews will be clearly documented to demonstrate that the intervention is necessary, proportionate and the least restrictive option to meet the resident's assessed needs and maintain their safety and wellbeing.
Timeframe: Immediate actions underway. Full rollout by 30th September 2026
Ongoing monitoring thereafter.
Responsible persons: CNMs; Person In Charge

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/10/2026
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.	Substantially Compliant	Yellow	31/03/2027
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of	Not Compliant	Orange	31/07/2026

	the incident within 2 working days of its occurrence.			
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	31/10/2026
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	30/09/2026