

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Lystoll Lodge Nursing Home
Name of provider:	Lystoll Lodge Nursing Home Limited
Address of centre:	Skehenerin, Listowel, Kerry
Type of inspection:	Unannounced
Date of inspection:	08 July 2026
Centre ID:	OSV-0000246
Fieldwork ID:	MON-0050720

About the designated centre

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

Lystoll Lodge Nursing Home is situated in the countryside, approximately one mile outside the heritage town of Listowel. The centre provides 24-hour nursing care, which is led by the person in charge, who is a qualified nurse. The centre is a two story premises and is registered to accommodate 48 residents. Bedroom accommodation consists of 28 single bedrooms and ten twin bedrooms. There is a variety of communal space, which includes a dining room on the ground floor and three sitting rooms, as well as an internal garden. The centre can accommodate both male and female residents requiring continuing care, respite care, convalescence care, dementia care, psychiatric care and end-of-life care. Admissions to Lystoll Lodge Nursing Home are arranged by appointment, following a pre-admission assessment of needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48
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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
Wednesday 8 July 2026	12:30hrs to 20:15hrs	Siobhan Bourke	Lead
Thursday 9 July 2026	09:00hrs to 15:00hrs	Siobhan Bourke	Lead
Wednesday 8 July 2026	12:30hrs to 20:15hrs	Caroline Connelly	Support
Thursday 9 July 2026	09:00hrs to 15:00hrs	Caroline Connelly	Support

What residents told us and what inspectors observed

This unannounced two-day risk inspection was undertaken by two inspectors of social services to follow up on a number of non-compliance's from the previous inspection. It was also carried out in response to unsolicited information received to the office of the Chief Inspector, that raised concerns regarding the quality and safety of care provided to residents. During the two days, the inspectors met with many of the residents and spoke with 12 residents in more detail. Inspectors also spoke with eight visitors.

As on the previous inspection, residents and relatives spoke very positively regarding the kindness and the care staff provided, however, a number raised concerns regarding staffing shortages with resultant delays in care occasionally in the early evenings and at weekends. Some relatives raised concerns with the inspectors, whereby they had identified a lack of managerial staff at the weekends and how several regular care staff had left the centre. Relatives told the inspectors that the new staff were a challenge for their relatives as they were not as aware of residents' needs and preferences.

As identified on the previous inspection, issues with regard to residents losing clothing in the laundry remained a concern for relatives of residents. These issues will be discussed further in the report. The overall findings of the report identified that although some improvements were seen in a number of areas, the overall governance and oversight of the service required significant action.

Lystoll Lodge Nursing Home is a designated centre for older people situated in a rural setting, outside the town of Listowel, County Kerry. The centre is a two-storey purpose-built nursing home, which is registered to accommodate 48 residents. There were 48 residents living in the centre on the days of this inspection. There were bedrooms to accommodate 30 residents on the first floor and 18 on the ground floor, with a lift available for residents' use.

The inspectors arrived unannounced to the centre at 12.30hrs on day one of the inspection and remained in the centre until after the night staff were on duty. The inspectors then returned to the centre the following day. The inspectors walked around the centre to meet with residents, staff and observe the daily routines in the centre. Staff were observed interacting with residents, in a kind and compassionate way and assisting them as required. Some of the residents living in the centre had a diagnosis of a cognitive impairment and could not converse with inspectors. The inspectors saw that these residents were very comfortable in the company of staff, who appeared to be aware of their preferences and dislikes.

The inspectors observed the lunch time meal being served on day one. On the ground floor, inspectors saw that residents were enjoying a social dining experience in the dining room, where tables were appropriately set and residents enjoyed

eating together with their friends. The inspectors saw that residents were offered a choice of main courses for the lunch time meal. Residents were very complimentary to the inspectors regarding the choices available at mealtimes and the home baked goods such as scones and cakes available to them. On the first floor, although there were more residents now attending the dining room since the previous inspection, the dining experience for residents was not conducive to a social dining experience. Residents sitting at the same table were served their meals at different times, whereby one resident had long finished their dinner before their table companions even received theirs. The system for delivering food to residents dining upstairs should have been improved by the introduction of a hot trolley system, however only one trolley was available upstairs and contained approximately six to seven meals therefore residents could not all be served together. The provider said two trolleys should have come up together so all residents could be served together but this was not rectified by management on the day despite a managerial presence being in the dining room at the mealtime. Also, a nurse was observed standing over resident assisting them to eat instead of sitting with the resident. This and other findings are discussed throughout the report.

There had been several improvements to premises since the previous inspection; the ceiling tile was replaced in the downstairs bathroom; a new call bell system had been installed and equipment in the sluice rooms was appropriately stored. Residents who spoke with the inspectors confirmed that their bedrooms were cleaned every day, and the provider informed the inspectors that new cleaning products had been sourced. However, as identified on the previous number of inspections, the layout of some of the privacy curtains in shared rooms, did not ensure that the privacy of both residents could be maintained, if the curtains were closed. The provider informed the inspectors that new curtain poles and curtains were in place, however, in a small number of rooms the privacy curtains were the wrong size, or did not enclose the bed space sufficiently, to provide privacy for residents in twin bedrooms.

Also in some residents' bedrooms, wardrobes were in bed space of other residents which made them difficult for residents to access, if the other resident had their curtains closed or were receiving personal care.

The inspectors saw that there were minimal activities during the morning of the inspection as the staff member assigned to activities was allocated to do a morning tea round on the first floor, therefore did not have time to do activities. During the afternoon of the first day of inspection, the inspector saw many of the residents on the first floor participate in a lively chair exercise session. On the second afternoon, an external musician was in the centre and many of the residents were singing along to old time music in one of the dayrooms on the ground floor. Residents' views on the running of the centre were sought through residents' meetings. An inspector reviewed the minutes of the most recent meeting and noted that feedback from residents was generally positive regarding the meals and food available in the centre. Two residents reported issues with missing items of clothing and residents were requesting that outings from the centre should be planned over the summer months.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations in this report.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social service to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended) and to review unsolicited information received by the Chief Inspector, pertaining to concerns regarding the care and safety of residents.

Following inspection of the centre in April 2026, a warning meeting was held with the registered provider at which they were advised that, should they fail to achieve compliance with the Health Act (2007) as amended, the regulations and standards made thereunder, the Chief Inspector may proceed with regulatory action, including stopping admissions to the centre. The findings of this inspection were that while the provider had taken action to improve compliance with Regulation 15; Staffing, Regulation 17; Premises, Regulation 27; Infection control and Regulation 28; Fire precautions.

However, the findings of this inspection identified significant deficits in the provider's governance and management arrangements for safeguarding. Inspectors found inadequate oversight by the provider and management team regarding the implementation, monitoring and effectiveness of systems intended to safeguard and protect residents. This included deficits in the identification, management and escalation of safeguarding risks. Furthermore, training and supervision of staff, complaints management and systems in place for notification of incidents were also found to be ineffective to meet compliance with the regulation.

The registered provider of the centre is Lystoll Lodge Nursing Home Limited, which comprises two company directors. Both directors are engaged in the running of the centre, with one director involved in the operational and non-clinical management of the centre and the second director directly involved in the daily maintenance of the centre. The person in charge of the centre remained on unplanned leave since April 2026 and the Chief inspector was appropriately notified of the deputising arrangements in place in their absence. The assistant director of nursing was acting person in charge at the time of the inspection. They were supported in their role by a clinical nurse manager and a team of nurses, healthcare assistants, housekeeping, administration and activity staff. The inspectors reviewed the rosters and from speaking with staff and residents, the number and skill mix of staff was appropriate on the days of inspection to meet the assessed needs of the 48 residents living in the centre.

An inspector reviewed the training matrix that was in place to monitor staff attendance at mandatory training such as fire safety, manual handling, managing responsive behaviour and safeguarding vulnerable adults. The assistant director of nursing was in the process of rolling out training for nursing staff on recognising residents at risk of clinical deterioration and staff had recently completed training on CPR. However, the inspectors observed some manual handling practices that were not in line with best practice, and several staff had not received training, and others were overdue training in manual handling. Other gaps in mandatory training were also identified and issues with a lack of supervision of staff; these and other findings are detailed under Regulation 16; Training and staff development.

There had been a high turnover of staff since the previous inspection, with twelve new staff employed since then. From a review of a sample of staff files, it was evident that records were maintained as required under Schedule 2 of the regulations. However, one staff member's reviewed file indicated that they had commenced employment in the centre before their Garda vetting disclosure was received by the provider. This is detailed under Regulation 21: Records.

Significant action was required by the provider to ensure appropriate oversight and management arrangements were in place. While information regarding risks to residents such as falls, weight loss, residents with skin tears and pressure ulcers were recorded weekly, from a review of records, some of this information was recorded incorrectly and not responded to by the management team as detailed under Regulation 23; governance and management. Audits were not completed in line with the schedule available in the centre.

Records of incidents occurring in the centre was maintained electronically. From a review of these records, it was evident that required notifications were submitted to the office of the Chief Inspector regarding residents who were admitted to hospital following a serious injury in the centre. However, safeguarding incidents that required notification and incidents where residents had unexplained absence from the centre were not. This is detailed under Regulation 31 Notification of incidents.

An inspector reviewed the complaints records that were maintained in the centre on both electronic and paper format. From a review of these records and from speaking with relatives and residents, it was evident that not all complaints were recorded and investigated as required in the regulations.

Regulation 15: Staffing

The number and skill mix of staff was appropriate to meet the assessed needs of the 48 residents living in the centre on the day of inspection. The inspectors saw that there had been an increase in the number of care staff available since the previous inspection to ensure that the twilight shift was covered seven days a week.

Judgment: Compliant

Regulation 16: Training and staff development

From a review of the training matrix maintained in the centre, a number of staff continued to require training appropriate to their role as evidenced by the following;

- there was a high turnover of staff since the previous inspection, with 12 new staff employed in the centre. A number of these staff did not have mandatory training including people moving and handling and the inspectors observed some poor moving and handling practices during the inspection which could lead to injury
- fire training and safeguarding vulnerable adults was also required for new staff
- two staff were overdue training in the safeguarding of residents and two staff were overdue fire training
- although a number of management staff were now on the training matrix, there was only evidence of their attendance at fire training but no other mandatory training
- complaints management training was required for members of the management team involved in management of complaints in the centre.

There was a lack of supervision of staff evidenced by the following findings;

- the dining room experience upstairs continued to be very poor with little effective supervision by management to ensure a social dining experience for residents
- poor manual handling techniques were observed which were not corrected by senior staff.

Judgment: Not compliant

Regulation 21: Records

An inspector reviewed a sample of five staff files and found that they contained the information required under Schedule 2 of the regulations. While all staff files reviewed had garda vetting disclosures in place; one staff file reviewed indicated that a person commenced working in the centre one week prior to the vetting disclosure being made available to the provider. This is not in line with safe recruitment practices.

Judgment: Substantially compliant

Regulation 23: Governance and management

As found on the previous six inspections of the centre, significant concerns remained with regards the governance and management of the service and the registered provider's ability to ensure that the service provided was safe, consistent and effectively monitored.

The provider was operating the designated centre contrary to condition one of the centre's registration, on which basis the centre is registered by the Chief Inspector. Two newly commissioned offices were observed to be in use in the centre. The oratory had been relocated to the first floor from the ground floor. While an application had been submitted by the provider on 26 January 2026, the application had yet to be granted to sanction the use of these rooms. Therefore, the centre was operating outside condition one of the registration as required in the Health Act.

The management systems in place were not sufficiently robust to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by the following:

- There continued to be a lack of oversight of fire precautions, and an immediate action was issued to the provider during the inspection to undertake a simulated evacuation of their largest compartment with minimal staffing levels.
- Management systems in place did not ensure residents' rights were upheld and there was a lack of oversight of residents dining upstairs as outlined under Regulation 9; Residents' Rights.
- There was a lack of oversight of training and staff supervision as outlined under Regulation 16: Training and Staff Development.
- There was a lack of oversight of notifications that required submitting to the Chief Inspector as identified under Regulation 31: Notification of incidents.
- Oversight of systems to ensure residents were safeguarded were ineffective as outlined under Regulation 8; Protection.
- While information regarding residents with falls, weight loss and infections were collected, from a review of records of this data, some of the information collated was incorrect and did not reflect the incidence of falls in the centre, there was no action taken to act on issues where concerns were identified, for example an increase in falls for residents.
- Communication systems across the management team were not effective or consistent. Minutes of meetings provided to the inspectors indicated that governance meetings between the provider and the person in charge were held infrequently. Furthermore key risks to residents such as safeguarding concerns were not discussed by the management team or actioned from the minutes reviewed. This did not ensure the provider had oversight of the quality and safety of care provided to residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of the records of incidents and residents' records, maintained in the centre, the inspectors found that not all notifications had been submitted to the Chief inspector as required as evidenced by the following;

A number of allegations or incidents relating to safeguarding of residents had not been notified to the Chief inspector as required.

Incidents where residents had unexplained absences from the designated centre had not been reported to the Chief inspector as required.

Quarterly notifications with regards to expected deaths, activations of fire alarms, the use of restraint and pressure ulcers had not been reported as required for Quarter one of 2026.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure that the systems in place to manage complaints were effective to comply with the regulations.

As found on previous inspections, no records of a written response to complainants were available to provide the complainant with the outcome of the investigation, the learnings made or the procedure to follow if a review of the complaint was required.

Not all complaints were recorded as required; residents who spoke with inspectors reported complaints they had raised but there were no records maintained of these issues. Other complaints had been actioned by the management team, but were not recorded.

There was no records available to indicate that trends in complaints or areas that required improvement in the centre were being monitored by the management team.

These are required to meet the regulation and to ensure that complaints are fully investigated and recommendations actioned to improve the service for residents.

Judgment: Not compliant

Quality and safety

The inspectors found that residents had good access to healthcare services and interactions between residents and staff were observed to be kind and respectful during the two days of the inspection. Nonetheless, the quality and safety of care to residents was impacted by the ineffective management systems and inadequate oversight of the procedures to ensure residents were safeguarded.

From a review of a sample of six care plans, it was evident that validated assessment tools were used to develop residents care plans. There was evidence of regular review from GPs and allied health care professionals such as dietitians, speech and language therapists and physiotherapists when required. While care plans reviewed were updated every four months, not all care plans were updated to reflect a resident's changing condition as outlined under Regulation 5; Individual assessment and care plan.

The provider had safeguarding policies and procedures in place that were intended to guide staff in recognising, responding to and reporting safeguarding concerns to ensure residents were protected from the risk of abuse. Staff who spoke with inspectors demonstrated their understanding of the provider's safeguarding procedures and were familiar with the process for reporting and escalating concerns. However, inspectors were not assured that where safeguarding concerns arose, they were recognised, recorded or investigated as required. These findings and others are outlined under Regulation 8; Protection.

Action had been taken by the provider to improve the premises since the previous inspection. A new call bell alarm panel had been purchased and call bells checked by inspectors were found to be in working order. The ceiling tile had been replaced in the bathroom downstairs and the inspectors saw that lockers and changing facilities were in use by staff. Some wear and tear was noted in some residents' bedrooms as outlined under Regulation 17; Premises.

The inspectors saw that cleaning practices had been enhanced and new cleaning products had been purchased by the provider. Residents who spoke with inspectors were satisfied with the standard of cleaning in their rooms. The sluice room storage had been addressed, and the inspectors saw that worn mattresses had been replaced as required, since the previous inspection. However, the inspectors saw that storage of waste was not in line with national guidelines as outlined under Regulation 27 Infection control.

The inspectors saw that fire exits in the centre were clear from obstruction and records indicated these were checked daily. Records indicated that the emergency lighting and fire alarm were serviced quarterly and annually as required. From a review of records of the weekly testing of the fire alarm, records indicated that

these were not consistently carried out; these and other findings are outlined under Regulation 28; Fire precautions.

A residents' meeting had been held since the previous inspection to seek residents' views on the running of the centre. Residents told the inspectors their choices regarding getting up and going to bed were respected. The activity co-ordinator facilitated a lively chair exercise class on the first day of inspection and in the afternoon of the second day, residents enjoyed a live music session. However, action was required to ensure that residents' right to privacy was protected as gaps remained in some of the curtains in the twin rooms when closed. These and other findings are outlined under Regulation 9; Residents rights.

Regulation 12: Personal possessions

As identified on the previous inspection, issues with regard to residents losing clothing in the laundry remained a concern for relatives of residents.

In some residents bedrooms, wardrobes remained in the bed space of other residents which made them difficult for residents to access if the other resident had their curtains closed or were receiving personal care.

Judgment: Substantially compliant

Regulation 17: Premises

Although the inspectors saw that many of the findings of the last inspection had been actioned by the provider, However, some wear and tear to bedroom walls and paintwork was required. A shower chair was noted to be rusted and requiring repair in one of the centre's bathrooms.

Judgment: Substantially compliant

Regulation 27: Infection control

While it was evident to the inspectors that the provider had taken action to address the the findings of the previous inspection; the following required action to ensure compliance with the national standards for infection prevention and control for community services (2018).

Waste management practices for external storage of waste was not in line with the national standards, as inspectors saw black bags were stored outside in an external area and was not in secure containers or bins.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not ensured by fire safety management and fire drills at suitable intervals, that residents, where necessary could be evacuated in the case of fire. The largest compartment in the centre was eight residents and night time staffing levels was only five staff. The provider had not simulated an evacuation of this compartment carried out with minimal staffing levels such as night time staffing levels. These were requested during feedback and the provider gave assurances that they would be submitted for review.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Improvements were seen in the management of medicines since the previous inspection as medications that required a modified format such as crushing were now individually prescribed as such in the sample looked at by the inspector.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure assessments and care plans were updated and reflected residents' current condition as evidenced by the following;

From a review of a sample of six care plans, action was required to ensure that residents care plans were updated when their care needs changed as evidenced by the following;

A resident who no longer required a urinary catheter, did not have their care plan updated to reflect this change in their condition. Another resident's care plan contained two different actions regarding providing guidance on management of a medical device, that may not clearly direct staff.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP) of their choice. Residents also had access to a range of health and social care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life, and palliative care.

Judgment: Compliant

Regulation 8: Protection

The inspectors were not assured that all reasonable measures to protect residents from abuse had been taken by the registered provider.

A number of new staff were not provided with training with regard to safeguarding of vulnerable adults and two staff were overdue refresher training.

A number of allegations or incidents with regard to safeguarding residents had not been investigated and managed to ensure that appropriate action was taken to protect residents. For example, whereby a resident alleged that a staff member was rough with them; this was not reported nor managed in line with the regulations. Another resident reported that they were disturbed by a resident entering their room, this incident was not reported or investigated in line with the centre's policy.

Judgment: Not compliant

Regulation 9: Residents' rights

While the inspectors found that some action had been taken by the provider regarding residents' rights since the previous inspection; the following required action;

There were no scheduled activities rostered for residents during the morning, to ensure they had appropriate facilities for occupation and recreation available to them.

As found on previous inspections of the centre, residents living in twin rooms right to privacy was not protected, due to the positioning of the privacy screens.

On day one of the inspection, residents were not afforded a sociable dining experience on the first floor, whereby the inspectors saw they were not served their meals at the same time. This was actioned by the second day of the inspection.

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	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Lystoll Lodge Nursing Home OSV-0000246

Inspection ID: MON-0050720

Date of inspection: 09/07/2026

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff have completed fire training by 05.08.2026. • Staff overdue for mandatory training and all new staff will complete the training by 21.08.2026 • Complaints management training will be facilitated on 21.08.2026 • Additional moving handling training was provided to staff by an external facilitator on 10.08.2026 and further training will be completed by 21.08.2026. • Additional safe guarding training is provided by the external facilitator with awareness around concerns in relation to poor manual handling techniques and the risks associated with it. Demonstration of safe techniques were provided during this training. For continuous improvement inhouse workshops will be facilitated to demonstrate best practice and ongoing supervision is being carried out by senior nurse/clinical nurse manager on duty. • Audits are ongoing to ensure all residents have necessary manual handling aids. Additional supplies would be procured if required to ensure safe practice. • Manual handling risk assessments and Resident care plans were updated to reflect the need to use correct aids to ensure safety and this was communicated to all staff. • Dining room on the first floor is supervised to ensure social dining experience for residents.	

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All Staff files have been audited and contain all information required under schedule 2 of the regulations. Safe recruitment practices are being followed at all times. Training matrix is updated and all mandatory training will be completed by 21.08.2026.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A fire drill was conducted with minimal staffing level on 13.07.2026 • The provider has ensured oversight of fire precautions with fire drills and evacuation being conducted monthly with minimal staffing levels. • Dining room on the first floor is supervised to ensure social dining experience for residents. • The training matrix is audited and ongoing training is facilitated based on staff training needs. • Provider will ensure all notifications under regulation 31 will be submitted on or before due date. • Provider will ensure all reasonable measures are taken in the facility to protect residents from abuse under regulation 8. Safeguarding policy has been reviewed. Our PIC, the designated safe guarding officer will review oversight of system to ensure residents are safeguarded. Assistant Director will complete safeguarding adults designated officer programme and will assume the role of the designated safeguarding officer in the absence of PIC. • There will be senior nursing staff or nurse manager and senior health care assistants in day and night shift including weekends in the facility.	

- Key performance indicators data will be reviewed at weekly quality improvement meetings and actions will be taken on all concerns identified. The data collected will be used to improve quality and will be utilized and discussed at the monthly governance management meeting and minutes will be recorded.

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

All notifications will be submitted on or before due date as per regulation 31.

Regulation 34: Complaints procedure	Not Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- Complaints policy is reviewed and training for management is booked on 21.08.2026.
- All complaints will be recorded as per the complaints policy. Records of written responses to the complainant and the outcome of the investigation and learning outcome will be documented.
- Senior staff/management will be on the roster during weekends.
- All concerns/complaints will be part of the weekly Key performance indicator and will be addressed at weekly quality improvement meetings and the learning outcome will be discussed at governance and management meetings.
- A review of complaints will be conducted monthly for trend analysis and quality improvement and recommendations actioned to improve the service of residents.

Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: • Wardrobes of the residents in the shared room will be located in their own bed space. • Laundry staff were allocated extra time to maintain wardrobes. An audit will be put in place to ensure all clothes are labelled correctly.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: New Shower chair was purchased to replace the existing one.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: • IPC link practitioner trainer is booked for October 2026. • Premises will be maintained by provider in line with regulation 27. • Waste management practices and storage will be in line with the national standards.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A simulated evacuation of the largest compartment of eight people with minimal staffing levels was carried out on 13.07.2026 and this will continue to be carried out on a monthly basis.	

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: All assessments and care plans were audited and corrective actions were put in place. Regular audits are ongoing to ensure compliance. The learning outcome of the care plan audits will be discussed at quality improvement meetings.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • The provider will ensure all reasonable measures are taken in the facility to protect residents from abuse under regulation 8. • Safeguarding policy has been reviewed. • Our PIC, the designated safe guarding officer will review oversight of system to ensure residents are safeguarded. • Assistant Director will complete safeguarding adults designated officer programme and will assume the role of the designated safeguarding officer in the absence of PIC. • Staff overdue for mandatory training and all new staff will complete the training by 21.08.2026.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • External facilitator is booked to provide safeguarding training applying a Human rights based approach (FREDA) for all staff in the facility. • Applying a Human rights based approach (FREDA) in health and social care: putting national standards into practice: 4 modules will be completed by all staff in the facility. • Additionally training is facilitated for senior management which will be attended by	

registered provider, admin staff and senior nursing management to create awareness on complaints management,

- Once a week morning resident outings to community has commenced since August 2026 and is ongoing. Activity roster will include resident activities for the morning.
- Fixtures will be put on privacy screen to ensure the resident's right to privacy.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	30/09/2026
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	30/09/2026

	and other personal possessions.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/08/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/08/2026
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	30/09/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	21/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	15/08/2026
Regulation 27(a)	The registered provider shall	Substantially Compliant	Yellow	30/08/2026

	ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.			
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	05/08/2026
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 the incident within	Not Compliant	Orange	01/08/2026

	2 working days of its occurrence.			
Regulation 31(2)	The person in charge shall ensure that, when the cause of an unexpected death has been established, the Chief Inspector is informed of that cause in writing.	Not Compliant	Orange	01/08/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	30/08/2026
Regulation 34(3)	The registered provider shall take such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a complaints or review officer.	Not Compliant	Orange	30/08/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into	Not Compliant	Orange	30/08/2026

	complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	30/09/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/09/2026
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	21/08/2026
Regulation 8(3)	The person in charge shall	Not Compliant	Orange	30/08/2026

	investigate any incident or allegation of abuse.			
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	30/08/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/09/2026