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:	Nazareth House Mallow
Name of provider:	Nazareth Care Ireland
Address of centre:	Dromahane, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	27 August 2026
Centre ID:	OSV-0000257
Fieldwork ID:	MON-0051287

About the designated centre

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

The Sisters of Nazareth opened Nazareth House Mallow as a nursing home in 1929. The Sisters developed a new nursing home in 2018; it is a three storey building with resident accommodation on the ground and first floor. Bedrooms comprise 120 single en-suite bedrooms. The new development includes a new entrance, reception and lobby area, coffee dock, lounges, community hall, hair salon, conference, meeting/training rooms and social club. The range of care needs provided by the Nursing Home are designed to meet the physical, cognitive, social, occupational, psychological and spiritual needs of residents admitted to the centre. Nursing care is provided on a long term basis or short term respite/convalescence basis to residents both male and female whose level of need and dependence may be deemed low, medium, high or maximum category. The centre provides 24 hour nurse-led care service, including general, respite, dementia, convalescence and palliative end of life nursing.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	120

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 27 August 2026	08:30hrs to 16:30hrs	Siobhan Bourke	Lead
Friday 28 August 2026	08:30hrs to 14:45hrs	Siobhan Bourke	Lead
Thursday 27 August 2026	08:30hrs to 16:30hrs	Louise O'Hare	Support
Friday 28 August 2026	08:30hrs to 14:45hrs	Louise O'Hare	Support

What residents told us and what inspectors observed

This was an unannounced inspection, carried out by two inspectors of social services over two days, to monitor compliance with the regulations. The inspectors arrived at the centre in the morning of the first day. Over the two days of the inspection, they met with many of the residents and spoke with over 30 residents to gain an insight into their experiences of living in the centre. The inspectors also met with 12 visitors during the two days. In addition, the inspectors observed interactions between staff and residents and reviewed a selection of documents. Overall, feedback from residents and their relatives was very positive regarding the quality of care they received from staff working in the centre.

Nazareth House is set on a large landscaped site, located in close proximity to the village of Dromahane. It is a three-storey building, with resident accommodation on the ground and first floors. The centre is registered to accommodate 120 residents. Residents are accommodated on the ground floor in three units; Larmenier could accommodate 30 residents, and Dromore and Holy Family accommodated 15 residents. Holy Family Unit was designated as a dementia specific unit. On the first floor, residents were accommodated in two units, each with 30 beds, namely, Hammersmith and Brittany. The main entrance was wheelchair accessible and led into the main concourse. The main entrance was staffed by a receptionist, who greeted visitors and directed them to which ever house they were visiting.

The inspectors saw that the premises was decorated in a warm and homely style with plenty comfortable seating and rest areas throughout the home. The ground floor had a large seating area that had photographs of residents displayed and had old style dresser with china and delph. There was also a coffee dock that residents and visitors could use. A sitting area near the coffee dock was used by many residents and visitors to sit and chat, during the two days. The chapel was used by many of the residents on a daily basis as mass was celebrated in the centre six days a week. Each of the houses had designated communal spaces such as a dining room, day room and a quiet room for residents' use.

During the walkaround of the centre, the inspectors saw that the majority of residents' bedrooms were personalised and had items of significance to residents such as their own furniture, paintings and family pictures. Residents had plenty storage and all bedrooms were single occupancy with ensuite showers and toilets. Residents confirmed with the inspectors that their bedrooms were cleaned every day. A resident told the inspector that their laundry was always returned in a timely manner and that the " laundry staff were so exact about everything." The inspectors saw that flooring in a number of residents' bedrooms was worn under the beds and some wear and tear on paintwork in some residents bedrooms walls was evident. While the centre was warm throughout, in one house on the first floor, an air

conditioning unit was in use as the first floor was reported to be very warm. This will be discussed further in the report.

Residents could freely access the well-maintained courtyards in the centre. The gardens had ample seating areas and raised flower and plant beds. Visitors and residents told the inspectors that they had really enjoyed the summer fete that was held outside the previous Sunday.

The inspectors saw that staff knocked before entering residents' bedrooms during the two days of the inspection and saw many person-centred interactions between staff and residents. Call bells were positioned near residents so that they could call for assistance when they needed attention. Residents told the inspectors that staff responded to them as needed. Residents spoke very positively regarding the care and kindness they received from staff. One resident told an inspector how the dining room staff were so aware of their food preferences and how they liked their drinks, that it was a great comfort to them.

The inspectors saw that mealtimes were a sociable experience for residents, with many of the residents choosing to eat in the dining rooms in each household. Residents who required assistance were provided with this in a dignified and respectful manner. Residents were very complimentary regarding the quality and choice of meals, snacks and food available to them.

The activities programme for the centre was facilitated by a team of activity staff, who provided both one-to-one support and group activities for residents. During both mornings, the inspectors saw them deliver newspapers and mail to residents' bedrooms and stop for chats with residents. One of the team also brought the therapy dog 'Kobi' to meet with residents at this time. Many of the residents attended mass in the chapel on both days in the morning. On the afternoon of the first day, an arts and crafts session was attended by a large number of residents where they were chatting together and creating art or knitting. This was followed by a quiz in the evening. Two of the residents were running the centre's shop that was stocked with treats, toiletries, cards and some clothes. A musician attended the centre on the afternoon of the second day and many of the residents were dancing and singing together and with staff which appeared like great fun. The centre had its own bus, whereby residents travelled to town to do shopping or go to coffee shops or other outings. The social club also had a magic table that residents could use for interactive games. Other activities available for residents were bingo, exercise classes, flower arranging and music. Residents who spoke with the inspectors confirmed that there was always something to do in the centre. Residents also said that they could get up and go to bed at a time of their choosing and that their rights were respected.

Residents' views on the running of the centre were sought through residents' surveys and residents' meeting that were held regularly. From a review of minutes of these meetings, it was evident that feedback from residents was acted on by the management team.

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

Capacity and capability

This was an unannounced inspection, carried out over two days, by two inspectors of social services, to monitor the registered provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013(as amended). The inspectors also followed up on the action taken by the provider to implement the recommendations made following an investigation of a serious incident that occurred in the centre. Overall, the findings of the inspection were that Nazareth House Mallow was sufficiently resourced to ensure the effective delivery of care in accordance with the statement of purpose. However, action was required to ensure that the management systems in place were effective with regard to notification of incidents and training and staff supervision as detailed under the relevant regulations.

The registered provider of Nazareth House Mallow is Nazareth Care Ireland, a company comprising of a board of directors, one of whom represented the provider. The registered provider is part of the Nazareth Care Group, which operates a number of other designated centres across the country.

There was a clearly defined management structure in place that identified lines of authority and accountability. There were two persons participating in management,(PPIM) to support the onsite management team in their roles. Both PPIMs were onsite in the centre for the two days of the inspection. The person in charge was full time in their position and was supported by an onsite team of two assistant directors of nursing and clinical nurse manager for each house in the centre. The person in charge attended monthly governance meetings with the provider, where all aspects of the service such as human resources, clinical outcomes for residents, incidents such as falls, pressure ulcers, infections, premises issues and complaints were discussed and actioned by the management team. The person in charge had resigned from the centre and was near the end of their notice period and one of the assistant directors of nursing was in line to replace this position. The Chief inspector had been notified of this change in role in line with the statutory time lines.

The number and skill mix of staff was found to be appropriate to meet the assessed needs of the 120 residents living in the centre during the inspection. There had been a significant turnover of staff in the six months prior to the inspection and recruitment was ongoing to replace these positions. From a review of rosters and speaking with staff and management, where gaps arose in the rosters, agency staff were employed to supplement the rosters.

Inspectors saw evidence that extensive staff training had taken place since the previous inspection, and further training was scheduled for the two weeks following inspection. A range of training courses were available to staff to educate them to provide care to residents, in topics including infection prevention and control, medication management and restrictive practice. Staff who spoke with inspectors were aware of their training and able to describe their roles and responsibilities. Inspectors saw that staff who were present on induction, on the days of inspection, were assigned to work with a senior member of staff to ensure they were appropriately supervised. However, while all staff had completed training in safeguarding vulnerable adults and people moving and handling, further training was required as outlined in Regulation 16: Training and staff development.

An inspector reviewed the records maintained of incidents and complaints that were maintained in the centre. From a review of these records, it was evident that where residents required admission to hospital following an injury in the centre or when an unexpected death occurred, these incidents were notified to the Chief Inspector within the required time frames. However not all allegations of abuse were notified as detailed under Regulation 31 Notification of incidents.

The inspectors saw that action was taken by the provider following serious incidents to implement recommendations to reduce the risk of recurrence. The inspectors saw that all staff had completed manual handling training. There were systems in place to ensure supervision of staff on induction and work experience. There was a system in place to ensure hourly checks of residents were completed and recorded. Care plans clearly indicated manual handling plans for residents. While the onsite management teams reported to the inspectors that they were contacted out of hours if any concerns arose in the centre, these arrangements were not formalized. The provider agreed on the day of inspection to formalise these arrangements so that on call staff were added to the rosters in the centre.

The inspectors reviewed the schedule of audits available and saw that there was close monitoring of care planning, infection control procedures, medication management and falls in the centre. From monitoring of key clinical risks to residents such as malnutrition, risks, pressure ulcers and infections, the management team had detected an increase in the incidents of pressure ulcer formation in the previous months and were implementing a quality improvement plan to address this concern.

There was evidence of good communication systems in place. The inspectors saw that the management team held regular meetings with all staff groups to ensure they were aware of any issues relevant to their roles. Staff who spoke with inspectors reported that they could raise any concerns with the management team.

Records were stored securely in the centre and made available to inspectors. A sample of staff files were reviewed and found to contain the information required by Schedule 2 of the regulations, including garda vetting and two written references. Garda vetting was seen to be in place before staff started working in the centre.

An annual review of the quality and safety of care provided to residents in 2025 was prepared and was available for review.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied for renewal of registration of the centre in a timely manner. Prescribed documentation was submitted and fees were paid.

Judgment: Compliant

Regulation 15: Staffing

On the days of inspection, the number and skill mix of staff was appropriate to meet the assessed needs of the 120 residents living in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

While the majority of staff had completed mandatory training, 22% of staff had not yet completed training in caring for residents who experienced responsive behaviour, and 10% of staff had not completed training in fire safety. Inspectors saw documentation that this was scheduled for the two weeks following inspection.

Judgment: Substantially compliant

Regulation 21: Records

Records as set out in Schedule 2, 3 and 4 of the regulations were securely stored in the centre and made available for inspection. A review of staff files found that all rostered nurses were registered with the appropriate professional body. A sample of staff files found that they contained the required information set out in Schedule 2 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had many effective management systems in place to oversee the quality and safety of care, action was required to ensure that all statutory notifications were reported as outlined under Regulation 31; Notification of incidents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose met the requirements of Schedule 1 of the regulations and was updated each year as required.

Judgment: Compliant

Regulation 31: Notification of incidents

From a review of incidents and complaints records in the centre while it was evident that all allegations regarding abuse such as neglect, were investigated they were not consistently notified to the Chief inspector as required in the regulations. Two such notifications were submitted following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

From a review of complaints records maintained in the centre, it was evident that complaints were recorded and managed by the person in charge who was the complaints officer. While written responses were sent where required to complainants they did not always include details of the review officer. This was actioned on the day of inspection.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures as outlined in Schedule 5 of the regulations were prepared in writing and made available to staff. Policies were updated at intervals not exceeding three years and reflected changes in regulatory requirements.

Judgment: Compliant

Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre

The provider ensured the Chief inspector gave notice as required regarding the absence of the person in charge from the centre for the duration of the absence and the deputising arrangements that were in place during this period.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents living in Nazareth House Mallow were provided with a good standard of care and attention from kind and caring staff. Some action was required regarding individual assessment and care planning and premises as detailed under the relevant regulations.

From a review of care plans, inspectors found that residents had good access to general practitioners (GPs), who attended the centre five days a week. Residents also had access to health and social care professionals, and inspectors saw from documentation that relevant referrals were sent in a timely manner. Care plans were informed by validated assessment tools that assessed risks such as skin integrity and risk of malnutrition, and were seen to be person-centred and generally detailed enough to direct care. Care plans were updated every four months; however, some required review to ensure that they were updated following relevant changes in care, as detailed under Regulation 5: Individual assessment and care plan.

The centre was well laid out to meet the individual and collective needs of residents living in the centre. The inspectors saw that residents bedrooms were cleaned every day as were communal areas. The inspectors saw that residents were using many of the spacious communal areas throughout the days of inspection such as the day rooms and dining rooms in each house, the chapel, seating area, assembly hall and sitting room on the ground floor. In general, residents bedrooms were personalised and well maintained, however flooring was observed to be worn and marked in some residents bedroom. The provider informed the inspectors that they were in the

process of seeking contractors to address this. These and other findings are outlined under Regulation 17; Premises.

The inspectors saw that alternatives to bed rails such as low beds and crash mats were in use in the centre to reduce the level of restrictive practices in use in line with national policy. The inspectors saw that staff interacted with residents in a respectful and dignified manner during the inspection.

Residents who spoke with inspectors gave very positive feedback regarding the quality and choices of food available to them at mealtimes. The inspectors saw that residents were offered snacks and drinks outside of mealtimes during the day. The lunch time meals were observed to be nutritious and wholesome on both days.

Residents who spoke with inspectors confirmed that they felt safe living in the centre and raising issues with staff. Staff had received training on safeguarding and further in person training had been scheduled for the week following inspection. The provider had systems in place for the management of residents' finances. Residents who had a safeguarding concern had a relevant care plan in place.

There were arrangements to support residents in accessing and retaining control over their personal property, possessions, and finances.

Residents had access to regular religious services, both in the centre's chapel and broadcast on television. Residents had access to radio, television, newspapers, telephones and internet services throughout the centre. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by attending residents' meetings and completing questionnaires. Residents also had access to independent advocacy services.

Regulation 10: Communication difficulties

Inspectors found that residents with communication difficulties had their needs assessed and clearly documented within their care plans. Residents were enabled by accessing appropriate communication aids and resources, such as communication boards to support residents with communication difficulties. This ensured they could communicate effectively and participate fully in daily life within the centre. Staff demonstrated a good understanding of each resident's individual communication requirements.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space to store their belongings in their bedrooms. The provider ensured that residents clothes were laundered regularly and returned to residents in a timely manner.

Judgment: Compliant

Regulation 17: Premises

The inspectors saw that flooring in a number of residents bedrooms were worn and marked and required replacement or repair. Paintwork in a small number of bedrooms was also noted to be chipped and marked. Two ceiling leaks were repaired by the maintenance team during the inspection.

Action was required with regard to the temperature of the first floor as residents and staff reported that the first floor was very warm, especially during the fine weather over the summer months.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were provided with wholesome and nutritious food choices for their meals and snacks and refreshments were made available at the residents' request. Menus were developed in consideration of resident's individual likes, preferences and, where necessary, their specific dietary or therapeutic diet requirements as detailed in their care plan. Daily menus were displayed on dining room tables so that residents were aware of the choices available to them. There was adequate numbers of staff available to assist residents with their meals. Assistance was offered discreetly, and in a respectful manner.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place. This contained all information as set out in Schedule 5. The registered provider had ensured that there was a plan in place for responding to major incidents and serious disruption to essential services.

Judgment: Compliant

Regulation 27: Infection control

The provider ensured that staff received suitable training with regard to infection prevention and control. There was good oversight of residents who were colonised with infection and antimicrobial usage was closely monitored in the centre. The inspectors saw that there was adequate resources to ensure the centre was cleaned daily and deep cleaning of resident's bedrooms also took place, as per the implemented schedule. Where required the provider consulted with additional expertise from the Department of Public Health, to obtain advice on the management of outbreaks.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

A comprehensive medication management policy was in place to guide staff on the safe administration, storage and disposal of medicinal products. Systems were in place to ensure that medicinal products dispensed to residents were securely stored in the centre. Records of medication administration and controlled drugs were maintained in line with professional guidelines. Medicinal products for disposal were segregated from other products, and a process was in place for them to be returned to pharmacy.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While generally care plans were person-centred, some action was required to ensure all care plans were updated in a timely manner or following a change in care as evidenced by:

- One care plan contained conflicting information in regards to restrictive practice which could lead to potential errors in care provided to residents.
- One care plan contained outdated information in regards to medication, and one care plan for management of a wound had not been updated to reflect that the wound had healed.
- Manual handling assessments were completed for all residents; however, documentation did not include all information specified in the centre's policy. This was actioned and completed by the second day of inspection.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were seen to have good access to medical and health care. A GP attended the centre five days a week. Residents had access to a range of health and social care professionals such as speech and language therapy and occupational therapy. A physiotherapist attended the centre weekly and was present on the second day of inspection. Inspectors saw from documentation that referrals were sent appropriately and in a timely manner. The centre had links to palliative care services to support residents receiving end of life care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

From a review of care plans, residents had person-centred detailed care plans in place, to guide staff, where residents experienced behaviour and psychological symptoms of dementia (BPSD). A register of all restrictive practices in use in the centre was maintained. There was evidence of alternatives trialled to reduce the number of restrictive practices in use in the centre. The inspectors saw that while staff interacted with residents in a dignified and respectful manner, a number of staff required training on management of responsive behaviours as outlined under Regulation 16 Training and staff development.

Judgment: Compliant

Regulation 8: Protection

The provider had taken reasonable measures to protect residents from abuse. Residents told inspectors that they felt safe living in the centre. Safeguarding training was delivered both online and in person, and staff who spoke with the inspectors were aware of their roles and responsibilities in reporting concerns. The provider was a pension agent for one resident in the centre, and appropriate systems were in place for managing residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors saw that residents were supported to have a good quality of life through good access to meaningful activities and social stimulation. There were three activity co-ordinators rostered each weekday in the centre to support both one-to-one and group activities in the centre. Residents had access to advocacy services as required. Residents views on the running of the centre were sought through regular residents' meetings and surveys. From a review of records of residents meetings, it was evident that action was taken by the management team in response to issues raised by residents. Residents who spoke with the inspectors confirmed their choices of how to spend their days and when to get up or go to bed were respected.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Regulation 33: Notification of procedures and arrangements for periods when person in charge is absent from the designated centre	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Nazareth House Mallow OSV-0000257

Inspection ID: MON-0051287

Date of inspection: 28/08/2026

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge will reconcile the training matrix against the staff roster and identify every staff member who has yet to complete training in responsive behaviours or fire safety. The sessions scheduled following inspection will be completed, with any absence followed by a replacement session. Until training is completed, staff will be supervised in the relevant duties. The person in charge will retain attendance and completion records and review the matrix weekly until it shows 100% completion of both topics for staff to whom the training applies. New starters will be included in the induction and training schedule.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The provider has reviewed the incidents and complaints identified during inspection and confirms that all required notifications have now been submitted to the Chief Inspector; none are outstanding. The person in charge will maintain a notification register linking each incident or allegation to its regulatory assessment, submission date and acknowledgement or recorded reason why notification is not required. The QSR will deliver further training on Regulation 31 to the person in charge and relevant management and clinical staff by 16 October 2026. The person in charge will	

reconcile the incident, safeguarding and complaints records with the notification register weekly for eight weeks, then monthly. The QSR will review this reconciliation at the monthly governance meeting and record and escalate any omission immediately.

Regulation 31: Notification of incidents	Not Compliant

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

The two notifications referred to in the inspection report were submitted following inspection. The provider confirms that all notifications required in respect of the matters identified have been submitted and that no notifications are outstanding.
The QSR will provide further training on the notification requirements of Regulation 31 and Schedule 4, including the requirement to notify the Chief Inspector within two working days where applicable, by 16 October 2026. The person in charge will assess every allegation of abuse, including neglect, promptly against the statutory notification criteria, record the decision and submission date, and review the notification register against incident, safeguarding and complaints records weekly. Any missed deadline will be escalated to the provider immediately, submitted without further delay and reviewed for learning.

Regulation 17: Premises	Substantially Compliant

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

The provider will complete a room by room survey of worn or marked bedroom flooring and damaged paintwork, record the affected rooms and prioritise remedial work according to condition and residents' needs. The maintenance team will verify that the two ceiling leaks repaired during inspection remain resolved. Contractors will be appointed and works will be planned with residents to minimise disruption.
The provider will assess temperatures on the first floor, including resident rooms during warmer conditions, document resident and staff feedback, and obtain specialist advice on a sustainable remedy. Interim measures will be recorded and reviewed while the permanent solution is arranged. The person in charge will review the works register monthly and retain completion evidence.

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:

The person in charge will ensure the care plans identified at inspection are reviewed with the residents and, where appropriate, their families. The restrictive practice record will be reconciled to remove conflicting instructions; the medication care plan will reflect current treatment; and the wound care plan will record that the wound has healed. The manual handling documentation completed during inspection will be checked for consistency with current assessed needs and centre policy.
The clinical nurse managers will audit a sample of care plans each month for review within four months and prompt revision after any change in need, including wound status, medicines and restrictive practice. Findings and corrective actions will be reviewed by the person in charge and reported through the monthly governance meeting.

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	16/10/2026
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	31/01/2027
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	16/10/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1)	Not Compliant	Orange	16/10/2026

	(a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of 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	16/10/2026