



**Health
Information
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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:	Craddock House Nursing Home
Name of provider:	Werlay Limited
Address of centre:	Craddockstown Road, Naas, Kildare
Type of inspection:	Unannounced
Date of inspection:	09 June 2026
Centre ID:	OSV-0000027
Fieldwork ID:	MON-0050750

About the designated centre

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

Craddock House Nursing Home is purpose-built and was established in 1999. It is located on the outskirts of Naas town, close to the general hospital and across from a secondary school. Residents have good access to amenities and have a range of recreational activities within a warm, welcoming and friendly atmosphere. There is unrestricted access to colourfully planted, paved and secure courtyards with open and sheltered seating areas along with many tactile items, including water features. The large courtyard garden has covered seating. There is a small courtyard garden off Rose Cottage and two other garden areas for resident use. The nursing home provides 24-hour nursing care seven days per week and is designed to ensure the comfort and safety of residents in a home-like environment. The nursing home provides a respite service, residential and convalescent care. Male and female residents are primarily over 65 years of age. The home can accommodate 89 residents over two floors serviced by a passenger lift and stairwells. It comprises 77 single and six double/twin bedrooms. Most bedrooms have full en-suite facilities or shared bathrooms, and eight single bedrooms that have access to communal toilet and bathroom facilities within close proximity. There are three main day and dining areas, called The snug, The cosy corner and The relaxation room. There are two conservatories and a spacious reception area for residents to relax in. In addition to these, there are two administration offices and three nurses stations, a hairdressing salon that operates three days weekly, a spacious oratory where mass is celebrated weekly, the main kitchen that services the households and a spacious multi-purpose room for family functions, meetings and staff training. Separate and adjacent to the main building are the laundry, boiler room and additional administration offices. To the front of the building, there are ample car parking spaces.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	81
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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
Tuesday 9 June 2026	08:00hrs to 17:20hrs	Aislinn Kenny	Lead
Tuesday 9 June 2026	08:00hrs to 17:20hrs	Maureen Kennedy	Support

What residents told us and what inspectors observed

On the day of this unannounced monitoring inspection, the inspectors spoke with eleven residents to gain insight into their experience of living in Craddock House Nursing Home. All residents spoken with were complimentary in their feedback and expressed satisfaction with the standard of care provided. Residents reported that the staff are 'lovely' and are 'very prompt in answering the call-bell'. The inspectors also spoke with several family members who were visiting on the day, who said that they would 'highly recommend Craddock House as a nursing home'. There were 81 residents living in the centre on the day of this inspection. Inspectors observed there was a welcoming and homely atmosphere in the centre. On arrival to the centre the inspectors reviewed the premises and met with residents and staff. Many residents were seen to be up and dressed, with some observed in the dining rooms having breakfast, and others being assisted by staff in their bedroom.

The centre is laid out on two floors. A large welcoming reception area is nicely decorated with information on display for residents and their visitors including hand hygiene information and complaints procedures. Residents' bedroom accommodation is divided into different units Cherry Blossom, Rose Cottage and Lily Valley and is comprised of 77 single and six twin-bedded bedrooms. Rose Cottage is a dedicated unit providing support for residents living with dementia. Residents had access to en-suites and shared shower or bath facilities. A number of residents' bedrooms were viewed and were seen to have been personalised with family photos, plants and other personal items. Residents said they were happy with their bedrooms. While residents' bedrooms were observed to be mostly clean and tidy inspectors observed that some areas of the centre were unclean and required urgent attention. The kitchenette in the Cherry Blossom dining area was visibly dirty, in need of repair and shelving that was required for one of the units had not been installed and instead was stored in the area. The unit was seen to be unfinished and did not facilitate appropriate storage. Staff belongings such as clothing and bags were also observed stored in the Cherry Blossom and Lily Valley dining rooms, which detracted from the homely experience.

During a walk around the centre, inspectors also observed that the outside courtyard staff area was untidy and unclean. Inspectors observed items such as old furniture stored in a haphazard manner throughout the courtyard and at the bin storage area and generator area. A door to the continence supplies store room was open throughout the day and dirt and debris had gathered there. A padlock had been installed on the side gate. Following a previous inspection, this gate had been fitted with a magnetic lock which would unlock the gate in the event of the fire alarm sounding. However, the padlock would now prevent the gate from being opened in the event of a fire. An immediate action was issued to the registered provider to remove the padlock before the end of the inspection and to have the area fully reviewed by a fire competent person. A second immediate action was issued to the provider to remove a towel which was preventing the closure of fire

doors at the entrance to the Cherry Blossom day room and this was removed on the day. This and further findings are discussed later in the report.

Inspectors observed residents engaging in activities throughout the day and some were observed having their hair done in the hairdressing salon. Other residents were relaxing in their bedrooms or other communal areas throughout the centre. Residents told the inspectors that there was 'always entertainment' in the centre and the inspectors observed residents returning from an arranged trip out on the afternoon of the inspection day.

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 impacted on the quality and safety of the service being delivered. The levels of compliance are detailed under the individual regulations.

Capacity and capability

Overall, the registered provider did not ensure that the oversight arrangements in place were sufficiently identifying, responding to and managing all the risks in relation to fire safety and infection prevention and control. Two immediate actions relating to fire safety were given to the provider on the day of the inspection and an urgent action was issued the following day in respect of the cleanliness concerns identified. The provider gave a satisfactory response to the urgent action and assurances that the issues would be fully addressed within the time lines provided.

This was a one day unannounced inspection carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). This centre had a chequered history of compliance and there were similar findings regarding the cleanliness of the kitchenette area since 2024. A previous inspection carried out in November 2025 had found some improvements however, this inspection again found failures to address this area and come into full compliance with the regulations.

Werlay Limited is the registered provider of Craddock House Nursing Home, which is part of the Virtue Integrated Care Group. The centre had a full-time person in charge who was new in the role and was supported by an assistant director of nursing, clinical nurse managers, a team of nursing staff, care staff, housekeeping, catering, administrative and maintenance staff. The person in charge reported to a senior person participating in the management of the designated centre and the registered provider. However, this inspection found gaps in the structures and systems of oversight as the nominated person participating in management did not attend the centre in line with the requirements outlined in the statement of purpose; Furthermore, there was no documented evidence to demonstrate their role in supporting the person in charge. Instead a regional director provided in person

support to the new person in charge and attended the centre on the day of inspection. Gaps in the management and oversight of service impacted on the effective and safe delivery of care in accordance with the centre's statement of purpose. Insufficient oversight of staff practices had resulted in the repeat findings relating to fire safety, infection prevention control and non compliance with notification of incidents as evidenced further in this report.

The centre is registered to provide accommodation for 89 residents and there were 81 residents residing in the centre on the day of inspection. Inspectors found that there was an appropriate level of clinical and support staff to meet the needs of the residents present during the inspection. There were eight staff vacancies for health care assistants and the use of agency staff was high in the centre. All staff nurses working in the centre had up-to-date registration pins and a sample of staff files reviewed confirmed that Garda vetting was in place prior to employment.

While training records were available for staff and most staff had received up-to-date mandatory trainings, the supervision of the cleaning of the kitchenettes was not sufficient. Audits carried out had not identified the issues or that maintenance was required.

Contacts for the provision of care were viewed and contained details of the service provided however, they did not all outline the fees associated with the service.

The management of complaints required review to ensure that there was an accessible and effective procedure in place for dealing with complaints. Inspectors found that there were some inconsistencies regarding the information that was on display in the centre on how to make a complaint and in the management of some complaints. From a review of the complaints received inspectors identified two concerns that required notification and had not been received by the Chief Inspector.

Regulation 14: Persons in charge

There was a person in charge who worked full-time in the centre. They had the necessary requirements of nursing and management experience as specified in the regulations.

Judgment: Compliant

Regulation 15: Staffing

A sample of staff duty rotas was reviewed, and in conjunction with communication with staff, residents and visitors, the inspectors found that the number and skill-mix

of staff were sufficient to meet the needs of the residents, having regard to the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to ensure that they carried out their work to the required standards in all areas. This was evidenced by the following findings:

- Supervision arrangements were not in place to ensure that environmental hygiene standards were in line with best practice standards for reducing the spread of infection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- The nominated person participating in management did not attend the centre on the basis that was outlined in the centre's statement of purpose to support the person in charge and the governance of the centre.

The management systems in place did not ensure that the service provided was safe and effectively monitored in all areas. This was evidenced by:

- The system in place to oversee the statutory requirement to report notifiable incidents to the Chief Inspector had failed to identify that all incidents had not been appropriately and timely notified.
- While daily environmental walkarounds were being completed by clinical nurse managers, significant risks found on this inspection were not identified. This included an environmental audit carried out in March 2026.
- While an audit of manager daily walkarounds had taken place it was unclear who had carried out the audit and how this audit informed a quality improvement plan. In addition, identified actions from the audit were open since April 2026, with no evidence of review or action taken.
- The oversight of complaints had not ensured that complaints were correctly identified and managed in line with policy.
- Management and oversight systems of fire precautions were not sufficiently robust to provide assurance that all staff would know what to do and how to evacuate the residents in the event of fire. Fire drills had not been carried out

on a consistent basis, and instead fire alarm testing was being labelled as a fire drills. While the provider did identify this issue, since May 2025 there had been only one fire drill carried out in the designated centre. • Immediate and urgent actions were issued to the provider during and after the inspection, and provider's response did provide assurance that the systems of oversight in respect of Regulation 27: Infection prevention control and Regulation 28: Fire Precautions had been strengthened.
Judgment: Not compliant
Regulation 24: Contract for the provision of services
From a sample of three reviewed, two residents' contracts did not contain the fees to be charged for the service.
Judgment: Substantially compliant
Regulation 31: Notification of incidents
A review of the records in relation to complaints received in the centre showed that there were two incidents, as set out in Schedule 4 of the regulations that were not notified to the office of the Chief Inspector within the required time frames.
Judgment: Not compliant
Regulation 34: Complaints procedure
Complaints procedures required review to ensure they were in line with the regulations. For example: • The complaints policy referred to the previous person in charge and contained information relevant to another centre. Information contained within the complaints procedure on display throughout the centre was confusing as it directed complainants to contact the assistant director of nursing as well as the complaints officer, who was the previous person in charge. Inspectors found that complaints were not always handled in line with policy as evidenced by:

- A response to a written complaint did not contain information relating to the Ombudsman as outlined in the centre's complaints policy.
- A complaint that was addressed to the person in charge was responded to and closed by the assistant director of nursing who had not been trained in dealing with complaints and with no input evident from the person in charge, as the nominated complaints officer.

Judgment: Not compliant

Quality and safety

Overall, the inspectors were assured that residents were supported and encouraged to have a good quality of life in Craddock House Nursing Home and that their healthcare needs were well met. Residents and visitors voiced their satisfaction with the care provided in the home. However, improvements were required in relation to the premises, infection prevention and control practices and fire precautions which will be discussed under their respective regulations.

The inspectors followed up on the compliance plan of the previous inspection regarding Regulation 5: Individual assessment and care plan, and acknowledge the improvements made. Care planning documentation was available for each resident, an assessment of each resident's health and social care needs was completed on admission and ensured that the resident's individual care and support needs were being identified and could be met. Residents' needs were assessed using validated assessment tools at regular intervals and when changes were noted to a resident's condition.

Residents' health and well-being were promoted, and residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as psychiatry services, tissue viability nurse, physiotherapy, dietitian, and speech and language, as required. There was a GP and occupational therapist on site on the day of inspection.

The premises was laid out to meet the needs of the residents. However, there were areas of the centre which did not comply with the requirements of the regulations as discussed under Regulation 17: Premises.

The rights of residents were upheld. There were opportunities for recreation and activities and residents were encouraged to participate in activities in accordance with their interests and capacities. Residents with dementia were supported by staff to join in group activities in smaller groups or individual activities relevant to their interests and abilities. There was access to advocacy with contact details displayed in the centre. There were resident meetings held to discuss key issues relating to the service provided.

The inspectors were assured that medication management systems were of a good standard and that residents were protected by safe medicine practices. Controlled drugs were stored safely and checked at least twice daily as per local policy. Checks were in place to ensure the safety of medication administration. There was good pharmacy oversight with regular medication reviews carried out. There was evidence of good oversight of multi drug resistant organisms (MDRO) and antibiotic stewardship.

The provider had some systems in place for the management of fire precautions within the designated centre and had arranged for a fire safety risk assessment, which had been completed in January 2026. Following this, an action plan was put in place to address the findings of the risk assessment. A fire door audit had taken place and installation of fire doors was being addressed by the maintenance team. The inspectors reviewed records of fire drills and found that they were not sufficiently demonstrating the effective evacuation of residents. This is further discussed under Regulation 28: Fire Precautions.

Regulation 13: End of life

The inspectors observed end-of-life care assessments and care plans which included consultation with the resident concerned and where appropriate, the residents' representative and reviewed by a doctor. Care plans were reviewed on an ongoing basis and updated with the changing needs of the residents.

Judgment: Compliant

Regulation 17: Premises

The following issues were identified, which were not in line with Schedule 6 requirements:

- Storage arrangements throughout the centre required review to ensure the premises was a clean, homely and inviting both internally and externally. For example; Several discarded items were observed in the courtyard area and beside the generator, such as furniture, commodes, and old fridge, trolley, medication cabinet. A white board was being stored in the oratory and inspectors observed several bags, coats and items belonging to staff stored in the communal areas used by residents. All of this was negatively impacting the homeliness of the environment.
- The décor in some parts of the centre was showing signs of wear-and-tear. Surfaces and finishes, including wall paintwork, were worn and there was damage to doorways in some residents' bedrooms and communal areas.

- Maintenance and repair was required in some areas; for example, tissue paper had been inserted in the locks of the doors of the conservatory to prevent draughts, shelves were broken in the cupboards of the Cherry Blossom day room, there was no plinth at the bottom of the base cabinets, and the sides of the worktop were unfinished.
- Not all aspects of the premises were cleaned and well-maintained, as further detailed under Regulation 27: Infection control.

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider had not ensured that all procedures, consistent with the *National standards for infection prevention and control in community services (2018)* were implemented by staff. For example;

- The cleaning processes for residents' equipment were inadequate. The 'I am clean' sticker system was in operation however, equipment with the sticker in place was observed visibly unclean, staff spoken with were unclear on the procedure for the use of sticker, and the guidance document available did not guide staff on the appropriate use of the sticker system in operation.
- Laundry skips when not in use were observed stored outside and visibly contaminated by the elements. Effective cleaning and decontamination of this equipment could not be assured prior to its use in the clinical area and posed a risk of infection to residents.
- A store room for continence supplies to be used by residents located beside the laundry was left open throughout the day of the inspection and there was dust, dirt and debris contaminating the area.
- Action was required in one of the living, dining communal rooms to ensure effective cleaning and decontamination could be carried out. The kitchenette area was visibly unclean. Cupboards were in disrepair with broken shelves placed against the wall behind the refuse container. The sides of the worktop were unfinished/unsealed, and therefore could not be cleaned thoroughly. The hand wash sink was dirty and did not drain sufficiently, leaving debris in the area.
- The floor of an equipment room was dirty and could not be effectively cleaned as there was equipment to be used by residents stored on the floor.
- Some equipment was visibly unclean such as a dustpan and brush and trolleys used to serve residents' food were visibly unclean.
- The external bin storage area was not clean and the bins were overflowing.

Under this regulation the provider was required to submit an urgent compliance plan to address the urgent risks. The provider's response did provide assurance that the risks were adequately addressed.

Judgment: Not compliant

Regulation 28: Fire precautions

Significant risks were identified in respect of the management of fire safety which required immediate action by the registered provider on the day of inspection. Further written assurances were requested and received following the inspection.

The registered provider did not take adequate precautions against the risk of fire, and did not provide suitable fire fighting equipment and building services. For example:

- A padlock had been applied to the side gate of the centre as a security measure, this gate was fitted with a magnetic lock which would open in the event of a fire. The padlock prevented the release of the gate, and this had not been reviewed by a fire competent person to ensure its safe use in line with evacuation procedures. Due to the immediate risk, the padlock was removed on the day at the request of the inspectors, and further written assurances were provided following the inspection that an alternative system had been installed.
- The cushions in the residents' smoking area were not fire retardant.
- Poor housekeeping practices impacted the overall fire safety. A tea towel was observed around a fire door handle in the Cherry Blossom day room which would have prevented the door from closing in the event of a fire. A skip was in close proximity to an exit door at the side entrance.
- An air conditioning unit had been installed in the treatment room of Rose Cottage. There was a hole in the wall surrounding this and it was not sealed to prevent the spread of smoke in the event of a fire.

The registered provider did not ensure by means of fire safety management and fire drills at suitable intervals that staff working in the designated centre were aware of the procedure to be followed in the event of fire and had the skills and capability to evacuate all residents from one compartment to another should it be required.

- Records showed that while fire drills had been carried out on a regular basis. However, they were not simulating the evacuation of residents and fire alarm tests were inaccurately being recorded as drills. This had been recently identified by the provider and there was one fire drill which had taken place in April 2026 that involved staff simulating a drill. Prior to this the last actual simulated drill was in April 2025. Consequently, there was a lack of assurance that all staff would know what to do and would effectively respond to evacuate the residents in the event of fire.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services
Medication management processes such as the ordering, prescribing, storing, disposal and administration of medicines were safe and evidence-based. There was good oversight with regular medication reviews carried out.
Judgment: Compliant
Regulation 5: Individual assessment and care plan
Care plans were personalised and contained detailed information specific to the individual needs of the residents. They were updated quarterly or sooner, if required. Care plans demonstrated consultation with the residents and, where appropriate, their family.
Judgment: Compliant
Regulation 6: Health care
The inspectors found that residents were receiving a good standard of health care. They had access to their general practitioner (GP) and to multi-disciplinary health care professionals as required.
Judgment: Compliant
Regulation 8: Protection
There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided support and guidance in recognising and responding to allegations of abuse.
Judgment: Compliant
Regulation 9: Residents' rights

Residents' rights were upheld in the centre and all interactions observed during the day of inspection were person-centred and courteous.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Craddock House Nursing Home OSV-0000027

Inspection ID: MON-0050750

Date of inspection: 09/06/2026

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: • A newly appointed housekeeping lead commenced on the 2nd of June 2026 and received a comprehensive, structured and evidenced induction. • The housekeeping lead completes weekly environmental hygiene audits covering all communal areas, external grounds and courtyards in addition to the kitchenettes, with findings recorded and any actions tracked to completion; these audit records are also reviewed by the Person in Charge. • As a further, independent layer of oversight, a separate monthly environmental audit is completed by the Regional Director. • The weekly environmental hygiene audits and the Quality Improvement Plan are both verified and actions are assigned to named individuals with completion dates by the Person in Charge, and progress is discussed at the weekly Governance and Facilities meeting with the Regional Director. This full suite of measures was in place and continues to operate by 30 June 2026. • Daily kitchenette cleaning checklists are completed with oversight and signed by the Clinical Nurse Manager in each house, commenced on 15th June 2026 and remain ongoing, with any issues or concerns arising actioned immediately and escalated to the housekeeping lead where repair or deep cleaning is required. • A monthly cross-check log comparing the housekeeping lead's audit schedule against the completed checklists was introduced on 15 June 2026 to confirm supervision is operating effectively, with results reported to the Regional Director at the weekly Governance meeting. • Staff supervision responsibilities for environmental hygiene have been reiterated to all Clinical Nurse Managers and form part of the induction for new staff. • Overall accountability for this supervision structure sits with the Person in Charge, with the Regional Director providing second-line oversight. Housekeeping lead audit findings and signed daily checklists are retained on file. • Any issue identified is required to be actioned within 24 hours, with escalation to the	

Regional Director where this is not met.

- The effectiveness of the revised supervision arrangements will be formally reviewed at three months, alongside the wider governance review referenced under Regulation 23.

Regulation 23: Governance and management

Not Compliant

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

- SOP for Kitchenette Hygiene was developed and issued for all kitchenette areas, defining IPC responsibilities by staff group, HACCP requirements, escalation pathways and the requirement for CNM validation, with all Catering, Housekeeping, Nursing, HCA and management staff in Cherry Blossom formally briefed; the Clinical Nurse Manager was assigned formal responsibility for daily and weekly validation of the kitchenette checklist and deep clean record, now a standing item at Daily Management and weekly Clinical Governance meetings.
- A revised walkaround checklist for CNMs, ADON and PIC was introduced, incorporating a dedicated IPC section covering storage, door security, external pathways and windowsills across each household kitchenette, external grounds and premises; walkarounds are conducted at least twice weekly by the CNM and ADON and weekly by the PIC, reported to the Regional Director weekly from 15/06/2026.
- IPC training records for all staff were reviewed, with a completion plan set for 30/07/2026 for any outstanding or expired training. QIPs arising from IPC audits and walkarounds are tracked to closure through the Craddock House governance framework, with any QIP not closed within the agreed timeframe escalated to the Regional Director.
- The Regional Director will conduct an unannounced visit within 30 days of the inspection and monthly thereafter to verify these management systems are operating as intended and was completed on 09/07/2026. Protected time has also been assigned to the IPC Link Nurse to attend the monthly clinical governance meeting from week commencing 15/06/2026.
- Craddock House's statement of purpose has been reviewed and corrected to confirm the Person in Charge continues to report directly to the Regional Director, removing the previous ambiguity around line management and governance support; this is reflected in the centre's revised organisational chart, issued 17 July 2026.
- The Regional Director is on site in Craddock house at least two days per week and is available by telephone and via Teams on other days, with the Group Director of Quality, Safety and Risk supporting remotely with scheduled visits and the Group Facilities Manager attending at least one day per week. The RDO also attends scheduled weekly Governance meetings with the COO as part of the group's overall governance management and structure.
- Incidents and complaints are discussed in detail at the weekly governance meeting thus ensuring that all required notifications are submitted and within the required

regulatory timeframe. HIQA notifications are a standing agenda item at that meeting, with the Regional Director checking the HIQA portal to confirm all notifiable incidents under Schedule 4 have been submitted on time; a notifiable-event tracker, cross-referenced against the HIQA portal and local file, was implemented on 11 June 2026 and is reviewed weekly to identify any at risk of missing the two-working-day requirement.

- This interim tracker remains the operating control while a system-integrated version within our electronic care management system is currently being developed, led by DQSR with date of completion due 30th September 2026.
- The Regional Director has delivered in-person coaching on environmental walkarounds to the entire management team, focusing on what “good” looks like; daily environmental walkarounds, signed and dated by the completing Clinical Nurse Manager, have formed part of the manager walkaround record since 19 June 2026, with actions assigned to a named team member and a close-out date.
- These action plans are tracked centrally and reviewed at the weekly minuted Governance and Facility meetings, and any action overdue escalated to the Regional Director; a monthly audit of the walkaround process itself was also introduced, with the first cycle completed in July 2026, to prevent a recurrence of the gap identified on this inspection.
- Following the inspection, all complaints are signed off exclusively by the Person in Charge on the electronic complaints management system, closing the gap where complaints could previously be closed by other staff without appropriate oversight. The management team, including the assistant director of nursing and clinical nurse managers, completed formal complaints management training on 30th June 2026.
- Weekly fire simulation drills, evacuating residents rather than testing the alarm alone, are overseen directly by the Regional Director, with an associated QIP from each drill, and drill records, including which staff took part and any learning identified, are reviewed at the weekly Governance meeting; a rolling three-month programme ensures all staff members attends and have a good understanding and working knowledge of the fire evacuation procedures in Craddock house.
- The Regional Director of Operations (RDO) is appointed as the person participating in management (PPIM) for Craddock House. We acknowledge and apologise that the PPIM commitment recorded in Craddock House’s current statement of purpose, 0.85 whole-time equivalent (WTE), has not matched the arrangement actually operating, which has been 0.48 WTE: a minimum of two days on site per week, rising to three or four days on occasions. This is a genuine gap between what is registered and what has been delivered, and it should have been corrected sooner. An application to vary the statement of purpose will be submitted without delay so the registered commitment reflects current practice, under a resourcing model in which senior management time is allocated according to relative risk across the group’s homes rather than a fixed figure per centre. This gap in the statement of purpose does not mean governance of Craddock House has been left short. On the days the RDO/PPIM is not physically on site, they remain directly available to the Person in Charge by telephone at all times and continue to provide hands-on operational and governance support remotely, so that oversight of the centre is not limited to scheduled site days. For transparency, the RDO’s wider portfolio comprised five nursing homes up to April 2024 and has comprised four since. Independently of the RDO/PPIM, the Group Director of Quality, Safety and Risk (DQSR), who reports directly to the Chief Operations Officer and sits outside the operational line, supports Craddock House through a scheduled programme of clinical and governance audits, a live risk register reviewed at the Executive Management Board, and defined

escalation triggers with corrective actions tracked to closure. Craddock House also receives the statutory Regulation 23 mechanisms operated across the group's nursing homes: an unannounced provider visit at least every six months with a written report, and an annual review of the quality and safety of care, both available to residents and the Chief Inspector on request. Cover during any absence of the RDO/PPIM is provided by another Regional Director of Operations, with the Chief Operations Officer as the escalation point at all times. We recognise this gap and are committed to ensuring the statement of purpose is kept aligned with actual practice going forward, with the application to vary tracked to completion through the centre's governance meeting.

- The Provider's clear intention is to align the registered arrangements with actual practice without delay, and we will bring forward the Application to Vary Condition 1 for Craddock House as a priority.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 24: Contract for the provision of services	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

- A full audit of all resident contracts was completed on 18 June 2026 to confirm that fee details are included in line with Regulation 24(2)(b).
- Addenda setting out the applicable fees were issued to the two residents whose contracts were found on inspection not to contain this information, and both signed addenda were filed in the resident's care record by 18 June 2026.
- Confirmation that fee information is included in the contract for care is now built into the post-admission audit tool completed for every new resident admission, closing the gap that allowed this omission to occur.
- Ongoing compliance with this requirement is monitored as part of the existing post-admission audit process, with any omission identified escalated to the Person in Charge for immediate correction, and audit records are retained on file.

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The gap in notification oversight is addressed as part of the wider governance response under Regulation 23: Governance and management. • HIQA notifications remain a standing agenda item at the weekly Governance meeting, and the Regional Director checks the HIQA portal during that meeting for verification purposes. • Following the inspection any incidents and or complaints are discussed with the senior management team daily, where it is identified if they are to be notified to the regulator and the procedure they are to be managed accordingly. This is evidenced on the electronic computerised care system. • A tracker, implemented on 11 June 2026, logs each notifiable event under Schedule 4 against its submission date so that any at risk of missing the two-working-day timeframe are identified in advance. • The two incidents identified on this inspection have been reviewed and notified to the Chief Inspector, and the Person in Charge has been reminded of their statutory responsibility for timely notification. • The notification tracker, together with confirmation of submission to the Chief Inspector for each notifiable event, is retained on file at Craddock house.	
Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • All complaints received are now responded to and closed exclusively by the Person in Charge, as the nominated complaints officer. • Following the inspection all written responses to complaints include information relating to the right to refer the matter to the Ombudsman, and a copy of the complaint's procedure is issued to the complainant along with acknowledgement of their complaint, so all complainants are aware of the full process and their options from the outset. • An electronic complaints and outcomes log, completed and live from 12 June 2026, is reviewed at the weekly Governance meeting to confirm responses are timely, consistent and compliant with policy. • The complaints policy on display throughout the home was updated on 11 June 2026 to remove reference to the previous person in charge and any information relevant to another centre, and now correctly directs complainants to the Person in Charge as the sole complaints officer, avoiding the previous confusion over the assistant director of nursing's role. • The updated policy has been shared with all staff, and the Person in Charge will	

complete a quarterly check to confirm the version on display in all communal areas remains current.

- Each of the management team have completed complaints management training. Completed on 30th June 2026.
- Evidence of Ombudsman information being provided in written complaint responses is retained on file and reviewed as part of the three-month governance review referenced under Regulation 23.
- Standard response templates for all complaint categories were reissued to the team in Craddock house on 17th July 2026.

Regulation 17: Premises

Substantially Compliant

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

- The painting decorating programme commenced on Monday 15th June and completed on 11th July 2026 including bedroom doors, communal areas including doorways and corridors. A planned painting programme is in place and areas identified on the environmental audits and walkarounds are immediately uploaded onto our facilities electronic app for completion. A full declutter and storage review was completed across Craddock house by 10 June 2026, including the courtyard, generator area and oratory, with all discarded items, furniture and staff personal belongings removed from communal and clinical areas, and a second skip ordered to clear the remaining volume of material. Following the inspection, any item removed from inside the home is placed at the designated bin area. A programme of ongoing storage audits, introduced 19 June 2026, has been included into the daily manager environmental walkaround, with oversight from the Regional Director, and the storage audit is now a standing item on the weekly Facilities meeting agenda. The outstanding repairs identified in the Cherry Blossom living room (broken shelving, missing plinths and unfinished worktop sides) including restructuring of shelving were completed on 07/07/2026, tracked through the weekly Facilities and Governance meetings to closure. The handwash sink was reviewed and in full working order and deep cleaned which was completed 11th June 2026. Monthly facility checks of all three kitchenettes are scheduled via the maintenance app, with the first cycle completed on 16 June 2026. Following each monthly internal and external environmental audit by the Regional Director, a risk-rated action plan is issued, with the Facilities Manager uploading all actionable items onto the maintenance app progress is discussed by the Person in Charge at daily catch-up meetings, with further updates at the weekly Governance meeting and the fortnightly Facilities meeting.

Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: A full review of the kitchenette was completed on 15/06/2026 in the presence of the Regional Director, Director of Nursing, housekeeping lead and Facilities Manager, and the deep clean schedule was completed the same day. The associated QIP covers reorganisation of the kitchenette, repainting of the Cherry Blossom living room and kitchenette areas, and replacement of internal and external shelving, with a completion date of 30/06/2026. A Kitchenette Daily Cleaning Checklist and Weekly Deep Clean Schedule were introduced across all households, including Cherry Blossom, from 15/06/2026, assigning specific duties to Catering, Housekeeping and Health Care Assistant staff, with each role signing individually to confirm completion. The Clinical Nurse Manager validates and initials the checklist daily and weekly, escalating any gaps to the Person in Charge within 24 hours. All staff in Cherry Blossom were briefed on their cleaning responsibilities alongside the new SOP, reinforced at handovers, team meetings and safety pause meetings. Craddock House is scheduled to go live on the electronic HACCP recording and audit system at the end of July 2026, with full activation in mid-August 2026, replacing the current paper-based records and building kitchenette hygiene questions directly into the daily and periodic audit templates. A revised SOP on decontamination of resident equipment was issued on 27 June 2026, with staff retrained and signed off on the "I am clean" equipment labelling system. Laundry skips are now stored securely indoors when not in use, and the continence supplies storeroom is kept closed and locked outside periods of use. Dustpans, brushes and food service trolleys have been replaced or deep cleaned, and the external bin storage area has a revised collection schedule to prevent overflow. These measures are overseen through the weekly IPC and Governance meetings, with completion verified by the Regional Director and checklist and photographic evidence retained on file. • The IPC action plan is reviewed at the scheduled monthly dedicated IPC meeting, with capacity to increase based on risk, chaired by the Person in Charge, with any outstanding item escalated to the Regional Director, and minutes retained in the IPC folder.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The skip previously stored near the side exit door was removed on 12th June 2026 and skips are now planned to locate in a suitable and safe space. • The chain and padlock on the side gate were removed on the day of inspection and	

have been permanently removed; the magnetic release mechanism has since been reviewed and confirmed effective by a fire-competent person, and written confirmation from that fire-competent person is retained on file.

- In November 2025, wander guard controls were added at the side gate to prevent residents leaving the building, ensuring the maglock stays locked and triggers a reception alarm when a resident wearing a wander bracelet approach.
- A subsequent review identified that this system did not alarm if the gate itself was left open without a wander guard trigger.
- To close that gap, our external provider has fitted door/gate contacts: an alarm on the fire door exiting to the laundry, sounding if the door remains open for more than 30 seconds, and an alarm on the gate exiting to the car park, sounding if it remains open for more than 3 minutes. Installation was completed and verified on 30 June 2026.
- Non-fire-retardant cushions in the residents' smoking area have been replaced with fire-retardant alternatives. Completed 28th July 2026.
- Staff have received toolbox talks reinforcing that nothing may be used to prevent fire doors from closing.
- The wall opening around the air conditioning unit in the Rose Cottage treatment room has been fire-sealed to prevent the spread of smoke the day following inspection.
- Weekly fire drills, simulating the evacuation of residents, commenced on 22 June 2026 with oversight from the Regional Director, replacing the previous practice of recording fire alarm tests as drills, and drill records are reviewed at the weekly Governance meeting to provide assurance that all staff have the skills and knowledge to evacuate residents safely.
- Written confirmation from the fire-competent person regarding the side gate release mechanism is retained on file.
- The rolling three-month drill programme will conclude and be formally reviewed at the end of September 2026, at the weekly Governance meeting, to confirm that all staff working in Craddock house have completed a fire simulated fire drill and have demonstrated the required competence, with results reported to the Regional Director.

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)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	15/06/2026
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	07/07/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	17/07/2026
Regulation 23(1)(d)	The registered provider shall ensure that management	Not Compliant	Red	16/06/2026

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	18/06/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Red	30/06/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/07/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means	Not Compliant	Orange	22/06/2026

	of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
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 2 working days of its occurrence.	Not Compliant	Orange	11/06/2026
Regulation 34(2)(a)	The registered provider shall ensure that the complaints procedure provides for the nomination of a complaints officer to investigate complaints.	Not Compliant	Orange	11/06/2026
Regulation 34(5)(a)(iv)	The registered provider shall offer or otherwise arrange for such practical assistance to a complainant, as is necessary, for the complainant to refer the matter to an external complaints	Not Compliant	Orange	11/06/2026

	process, such as the Ombudsman.			
Regulation 34(7)(a)	The registered provider shall ensure that (a) nominated complaints officers and review officers receive suitable training to deal with complaints in accordance with the designated centre's complaints procedures.	Not Compliant	Orange	30/06/2026