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:	Craddock House Nursing Home
Name of provider:	Werlay Limited
Address of centre:	Craddockstown Road, Naas, Kildare
Type of inspection:	Unannounced
Date of inspection:	07 November 2025
Centre ID:	OSV-0000027
Fieldwork ID:	MON-0048750

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:	83

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
Friday 7 November 2025	07:30hrs to 16:30hrs	Aislinn Kenny	Lead
Friday 7 November 2025	07:30hrs to 16:30hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

From what residents told the inspectors and what they observed, Craddock House Nursing Home was a nice place to live. Most residents living there told inspectors " It's nice here, staff respond when needed and are kind and gentle", "The staff are beautiful people, I have no concerns". Another resident said "anything I ask them for they bring, I am happy enough with the care". Inspectors spoke in more detail with three visitors and eight residents during the inspection.

The inspectors arrived to the centre in the early morning and walked around observing the morning routine for residents. The inspectors spoke with staff who had been on the night shift and observed the handover that took place in all units. During the morning most residents were observed having breakfast in their bedrooms, while some residents in Cherry Blossom and Rose Cottage were eating in the dining room with staff assistance. Shortly after breakfast, residents received morning care with staff observed knocking on doors before entering residents' bedrooms and announcing their arrival prior to entering.

The centre is laid out over two floors and is divided into three units, Lily Valley, Rose Cottage and Cherry Blossom with accommodation provided in 77 single and six twin bedrooms. The centre provides long-term care to residents. Rose Cottage is a dedicated unit providing support for residents living with dementia. Overall, the building was homely, bright and well-maintained. Most areas were generally clean however, some equipment for use by residents were seen to be unclean and required attention. Inspectors observed the numbers of housekeeping staff on the day and were not assured of the systems that were in place to cover staff vacancies in this area. Inspectors also observed a number of chair coverings in Rose Cottage which were worn and would not support effective cleaning.

Throughout the day inspectors spent time in the communal areas and walked around the centre at various times to observe and listen to interactions taking place. Residents' call-bells were observed to be answered and responded to in a timely manner throughout the day.

Inspectors observed lunch being served, food served to the residents appeared to be wholesome and nutritious. Residents said they were given the choice to eat in the dining rooms or their own bedroom. Most were observed enjoying the company of other residents in the dining rooms and mealtime was a sociable experience for most residents. The tables were set in a homely manner, with condiments and drinks within easy reach of residents, enabling them to maintain their independence. In Rose Cottage pictorial menus were on display to enable residents to make their choices. For residents who required assistance there were plenty of staff available to provide assistance and in some units staff were observed doing so, in a kind, discreet and unhurried manner. Residents praised the food in the centre stating "the

food is good". Snacks and drinks were made available to residents outside of regular mealtimes.

In general activities were well-organised, residents were observed to participate, and enjoy the activities provided on the day of the inspection in line with their capacities and capabilities. The inspectors observed residents engaging in chair exercises, which was popular with the residents. In addition, residents who were unable to engage with group activities were also observed to receive one-to-one support from the staff team. There was a hairdressing room in the centre and residents enjoyed attending this service on a weekly basis. There was a selection of newspapers available for residents to read and all bedrooms were observed to contain televisions. Residents were observed relaxing in various areas of the centre throughout the day such as the reception area, conservatory and day rooms.

Visitors who spoke with the inspectors also confirmed that they were very satisfied with the care their loved one was receiving in the designated centre and praised the staff and management who, they said, were very approachable. Inspectors also spoke with a numbers of staff throughout the day. In particular staff in Rose Cotage talked about the positive impact on the residents since staffing levels have been increased following the previous inspection. The hours allocated for meaningful activities had also increased and inspectors observed a buzzing atmosphere in the dementia unit, with plenty of music and laughter throughout the 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 the quality and safety of the service being delivered.

Capacity and capability

Overall, this inspection found that residents received good care and were happy within the designated centre. The provider had implemented improvements in respect of staffing levels and staff allocations to better meet the needs of the residents. While there was evidence that this had positively impacted on the care provided to the residents, some further improvement was still required. In particular, the provider was required to ensure the necessary resources were in place to ensure effective cleaning at all times in the centre. On this inspection, the inspectors also followed up on the compliance plan submitted by the registered provider following the previous regulatory inspection in June 2025 and information, both solicited and unsolicited, received since then. Notwithstanding the improvements seen since the last inspection, inspectors found that this provider was operating in a reactive manner to compensate for the significant governance and management changes and staff turnover that had occurred over the previous three months.

Werlay Limited is the registered provider for Craddock House Nursing Home. It is part of the Virtue group who own and run a number of nursing homes in Ireland. On the day of the inspection the regional director was present in the centre to support the person in charge and management team.

There had been significant changes to the management structures since the previous inspection. The person in charge had left and at the time of this inspection a new person had been appointed by the provider and proposed to the Chief Inspector of Social Services to step into this role. They worked full-time in the centre and are further supported in their role by an assistant director of nursing (ADON), clinical nurse managers, nurses, health care assistants, activity coordinators, catering, housekeeping, laundry and administrative support. Inspectors reviewed the staffing structure and found that significant changes had been made to the management team including the change to the person in charge, a new ADON and two new clinical nurse managers. Furthermore, a person participating in management appointed to support the operational management team had also left and not replaced. The regional director had maintained a consistent presence in the centre to support all these changes to the local management team which, along with the increase in staffing resources, had enhanced the care delivery to residents. It was evident that the regional director was very hands-on and provided effective leadership to the team at a time of heightened risk for the designated centre. On the day of the inspection staffing vacancies included a clinical nurse manager, four staff nurses and four health care assistant vacancies. To mitigate against these shortages and staff turnover, the provider had voluntarily stopped admissions to the centre over the previous two weeks, which had also contributed to stabilising the centre. The registered provider was actively recruiting or had already recruited for these roles and some new staff were due to start in the coming days and weeks. Nevertheless, it was evident that one housekeeping staff vacancy was not being appropriately covered in the short-term. This is further outlined under Regulation 15: Staffing.

The registered provider had arranged for enhanced staff training as a response to the findings of the previous inspection. Staff were facilitated and encouraged to attend both mandatory and other relevant professional training offered in order to meet the needs of residents. In particular, there was a focus on internal training specifically addressing the knowledge gaps identified from the previous inspection. These had been completed in the area of infection prevention control (IPC) and staff were due to complete further training in managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Inspectors reviewed a sample of staff induction records and found that there were supervision arrangements in place for new staff members.

While the provider had a range of oversight management systems in place, inspectors found that these systems needed to be strengthened and sustained to continue to meet the needs of the residents. Audit systems were in place to monitor key areas of service provision, such as falls, complaints, infections, care plans, restrictive practice and wounds. Inspectors found that the auditing process in some areas required strengthening to ensure the service provided was safe and

consistent. In addition to this, staffing resources were not fully in line with the statement of purpose. This is discussed in more detail under Regulation 23: Governance and management.

Inspectors reviewed the accident and incident log maintained in the centre and found that notifiable incidents were submitted to the Chief Inspector of Social Services in line with regulatory requirements.

Regulation 15: Staffing

The registered provider had not ensured there was an appropriate skill-mix of staff related to the assessed needs of the residents and the size and layout of the designated centre. This was evidenced by:

- A vacant housekeeping role was being covered internally by existing staff, and at times the housekeeping supervisor. This meant there were less hours available per week for the oversight of the cleaning and staff practices.
- On the day of the inspection, a staff member's leave had not been covered which meant there were four housekeeping staff on shift instead of five, to cover all three units. This was not appropriate to maintain the cleanliness standard required on all units and meet the needs of the residents

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role and demonstrated an appropriate awareness of their training. Staff had also completed enhanced training relevant to infection prevention control. While some gaps were noted in all trainings, refresher training was booked and a schedule of trainings was in place to address these.

Judgment: Compliant

Regulation 23: Governance and management

Resources required review to ensure the effective delivery of care in accordance with the statement of purpose; For example:

- A person participating in management had recently left their role and this role had not been filled. This was required to ensure the registered provider was

operating in line with its conditions of registration and provide governance oversight to the new management team. The presence of the regional director four days a week in the centre to support the new team was not sustainable in the long-term.
- A clinical nurse manager role was not fully filled, which was a repeat finding from a previous inspection. Inspectors acknowledge this role was being filled with staff nurses in the interim, however it further weakened the oversight structures.

The inspectors found that the registered provider had management systems in place to monitor the quality of the service provided; however, some actions were required to ensure that these systems were sufficient to provide a safe, appropriate and consistent service. For example:

- From a sample of call-bell checklists reviewed, inspectors found that they were not always being completed.
- Infection prevention control audits had not been completed despite a recent outbreak in the centre and the audit template used did not include the monitoring of equipment for use by residents.
- While provider's care planning audits had identified deficits, insufficient steps had been taken to meaningfully address them. Systems in place to monitor residents' care required improvement to ensure there was sufficient management oversight of repositioning records and residents' location checks. Further oversight of residents' care plans was necessary to ensure that residents' care needs were accurately documented in residents' care plans.
- The complaints procedure on display required updating to ensure residents and their families had accurate details for the complaints officer. Inspectors saw that in some of the units the name of the previous person in charge was still displayed as the nominated complaints officer.
- The electronic reporting systems for tracking progress on maintenance logs was required to be further strengthened.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record of all accidents and incidents involving residents was maintained in the centre. All accidents and incidents as specified by the regulations were notified within the required timescales.

Judgment: Compliant

Quality and safety

While some areas for improvement were identified in respect of the quality and safety of the service received by residents, overall residents were supported to have a good quality of life in a pleasant and comfortable environment. Findings confirmed that residents had access to good quality health care, and a well-organised programme of social activities. Notwithstanding these positive findings, this inspection found that further actions were required in relation to assessment and care plan and implementing effective infection control measures to ensure that the service provided is safe, appropriate and consistent.

Inspectors found that the premises was generally well-maintained. Action had been taken by the provider to address the findings of the previous inspection and floor coverings had been repaired. A new doorbell system had also been installed and was being tested on the day of the inspection.

Residents' needs were assessed on admission to the centre, through validated assessment tools. However, from a sample of care plans reviewed the care plans did not provide clear guidance to staff with regard to residents' specific care needs and how to meet those needs. Inspectors found that continence assessments had not been completed for some residents and risks to residents such as risk of falls or elopement from the centre, while identified, did not have adequate controls and care plans in place to guide staff how to manage these risks. Improvement was also required to ensure that sudden weight loss was assessed appropriately, investigated and managed in a timely manner and documented. This and other findings are further discussed under Regulation 5: Individual assessment and care plan.

Residents' dietary needs were met. Food was freshly prepared and cooked on site and residents expressed overall satisfaction with food, snacks and drinks available to them. Choice was offered at all mealtimes and adequate quantities of food and drink were provided. There was adequate supervision and assistance provided at mealtimes. Dining areas were appropriately equipped to meet the needs of the residents.

Residents' rights were upheld. Residents had access to television, newspapers and other media. There were facilities for meaningful occupation and entertainment. It was evident that residents were encouraged to maintain their independence and to make choices about how they would like to spend their day. Residents were well-supported to maintain their links with family and friends and visitors were seen coming and going on the day of the inspection.

Refresher training in managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had been booked for staff that were due to attend. Care plans were in place for residents who displayed responsive behaviours and on the day, these appeared to be managed in a way that kept residents, visitors and staff safe, while also having a minimal impact on the person

exhibiting these behaviours. A restrictive practice register was maintained in the centre and was reviewed on a regular basis.

Inspectors found that there were improvements in the management of infection prevention and control since the previous inspection and the provider had implemented their compliance plan actions. Notwithstanding, there were some areas that were identified on the day of the inspection that required addressing to ensure the service was safe and appropriate. This is further discussed under Regulation 27: Infection control.

Regulation 17: Premises

Inspectors found that the premises was maintained and appropriate for the number and needs of the residents in the centre.

Judgment: 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. Specific dietary or therapeutic diet requirements were detailed in each resident's care plan.

Judgment: Compliant

Regulation 27: Infection control

Notwithstanding the improvements made in this area, further strengthening was required to ensure compliance with the *National Standards for Infection Prevention and Control in Community Services (2018).* For example:

- No formal infection prevention control (IPC) audit had been carried out since July 2025, despite the centre having a recent outbreak.
- The management of residents' equipment required further review. A number of wheelchairs had not been cleaned to an appropriate standard. In addition, other wheelchairs were observed to have breaches in integrity of their covering. This did not provide assurance that they could be effectively cleaned. No specific audits were in place to monitor and review the cleanliness and integrity of equipment.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that significant action was required in relation to ensuring care plans were based on assessed needs and were reflective of residents' current condition. This was evidenced by the following:

- Residents had a care plan in place for meeting their nutritional needs. However, the assessment tool which was used to calculate residents' risk of malnutrition was not always accurately calculated and required review.
- Care plans were not clear and conflicting information was recorded in some residents' care plans such as the level of staff assistance a resident required and information relating to wounds and pressure ulcers were incorrectly recorded. This did not provide assurance that residents' needs were being met in these areas.
- Continence assessments were not in place for most residents which did not sufficiently guide care in this area.
- There was conflicting information in one residents' care plan which indicated that the resident's location should be checked every 15 mins. Records reviewed in relation to this found that the resident's location was to be checked every 30 mins. Upon further review inspectors found that these checks were not being consistently carried out by staff. This posed a significant risk and had not been identified by the provider's own internal management systems.
- Some care plans were not used in an effective manner to guide staff in how to provide care to the residents, and instead they were used as a chronological log of incidents that had taken place involving the residents. Others contained historical data that was no longer relevant to the current care needs and could cause confusion.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The inspectors observed that on the day of the inspection staff had the knowledge and skills to manage behaviour that is challenging. Restrictive practices were appropriately monitored in the centre and residents had a risk assessment completed in line with national guidance.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Craddock House Nursing Home OSV-0000027

Inspection ID: MON-0048750

Date of inspection: 07/11/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The management team became aware of the unforeseen vacant housekeeper role the day prior to the HIQA inspection, which was advertised on the same day.In the interim, an existing housekeeper has increased her hours to full-time, and any vacant shifts have since been filled by agency housekeeping staff until the newly recruited housekeeper commences in their role when they are fully compliant with Schedule 2 requirements. On the day of inspection, there were 4 housekeeping staff on duty, with a gap of 1 housekeeper shift unfilled due to short notice. Additionally, while short-notice staff absences are sometimes unavoidable, the centre has robust systems in place to ensure prompt escalation, effective risk management, and ongoing monitoring to maintain resident safety in line with Regulation 15. This includes a formal Service Level Agreement (SLA) with approved staffing agencies to ensure timely access to suitably qualified and vetted staff when required. Agency usage operates as a contingency measure only and is subject to governance oversight, with staffing levels, skill mix, and the impact on quality and safety reviewed through the clinical governance framework.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance and management oversight are being maintained through weekly senior management meetings and daily operational reviews by the Regional Director. The Regional Director will continue to be in Craddock House at least three days per week until January 31st, and from 01st February will be present in the centre 2 and 3 days on alternate weeks. The Director of Quality, Safety and Risk will also be present at the	

centre for 1 day per week with a PPIM in place.

A newly appointed Director of Nursing commenced on Januray 01st, 2026 and is being inducted by the Regional Director. Following their successful induction, the interim roles currently in place will revert to their previous roles, resulting in 3 full-time Clinical Nurse Managers in post.

Until the 31st January 2026, experienced senior staff nurses have been assigned to monitor and oversee the delivery of care, supported by the interim Assistant Director of Nursing and the interim Director of Nursing.

Immediate action has been taken to ensure completion of all scheduled call bell audits. A daily compliance tracker has been introduced, monitored by the management team and discussed at Daily Management meetings, ensuring that all planned call bell audits are completed and occur at different times throughout the day and night in different resident rooms within each house.

The Comprehensive Infection Prevention and Control audit schedule has been revised to include the equipment used by residents, changing from every 4 months to bimonthly, or sooner if an outbreak occurs occur. The revised Infection Prevention and Control audit was completed over 2 days with an associated Quality Improvement plan on 12th December 2025. During the outbreak, Daily Infection, Prevention and Control Checklists were completed, and any required actions or improvements were rectified at that time.
We have initiated a structured program to strengthen nursing documentation practices. This includes comprehensive training for all nurses and the management team on completing detailed assessments and clinical risk evaluations, such as the MUST assessment tool. This training will be fully completed by 31st December 2025.
Individual care plan training sessions are ongoing with each nurse to ensure accuracy and consistency. Additionally, all current resident documentation, including comprehensive assessments, clinical risk assessments, and care plans, will be thoroughly reviewed and updated by 31st January 2026.

A formal training schedule has been implemented to align with care planning requirements, nursing documentation standards, and the use of clinical assessment tools. This ensures that all registered general nurses possess the necessary knowledge and skills to maintain accurate resident assessments and associated care plans.

All resident repositioning and location checks are being completed on the electronic computerised care record system. The frequency of all resident care checks is discussed at each handover, attended by a member of the management team.
The management team also completes spot checks to ensure the resident's care plan is being adhered to with regards to the prescribed frequency of resident care and these spot checks are included on the Daily Management Checklist and are discussed during the Daily Management meeting.

The complaints procedure has been updated to reflect the current complaints officer in all three houses and in the reception area.
The facilities team are aware and are providing written updates or progress of facilities

items outstanding on the facilities electronic app. A weekly review of maintenance logs is now part of the governance meeting agenda.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
As outlined in our compliance plan under Regulation 23 (Governance and Management), The Comprehensive Infection Prevention and Control audit schedule has been revised to include the equipment used by residents, changing from every 4 months to bimonthly, or sooner if an outbreak occurs. The revised Infection Prevention and Control audit was completed over 2 days, with an associated Quality Improvement plan, on 12th December 2025 by the Group Director of Quality, Safety and Risk. During the outbreak, Daily Infection, Prevention and Control Checklists were completed, and any required actions or improvements were rectified at that time.

An audit was completed on all existing wheelchairs and residents' seating, resulting in the purchase of new wheelchairs and resident seating chairs. All existing wheelchairs were deep cleaned, and resident sitting chairs in each house are on a deep cleaning schedule, which are completed since 31st December 2025. Each house has its own individual house equipment inventory and scheduled cleaning procedure record, which will be included in the revised IPC audit scheduled to be completed bi monthly.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
Individual care plan training sessions are ongoing with each nurse to ensure accuracy and consistency. Additionally, all current resident documentation, including comprehensive assessments, clinical risk assessments, and care plans, will be thoroughly reviewed and updated by 31st January 2026.

A formal nursing documentation training schedule has been implemented to align with care planning requirements, nursing documentation standards, and the use of clinical assessment tools. This ensures that all registered general nurses possess the necessary knowledge and skills to maintain accurate resident assessments and associated care plans.

Prior to the inspection, 75 per cent of registered nurses attended wound care and pressure ulcer management training provided by a specialist in that field. Currently, the pressure ulcer and wound care plans are checked weekly by the clinical nurses' managers on duty to ensure all information is correctly recorded.

All resident repositioning and location checks are being carried out on the electronic care record system. The frequency of all resident care checks is discussed at each handover which a member of the management team attends. The discrepancy in location check intervals was addressed on the day of inspection.

The management team also conducts spot checks to ensure the resident's care plan is adhered to regarding the prescribed frequency of resident care and monitoring needs. These spot checks are included on the Daily Management Checklist and discussed during the Daily Management meeting.

The Comprehensive continence assessments are completed for all residents and are reflected in the residents care plan.
We have initiated a structured program to strengthen nursing documentation practices. This includes comprehensive training for all nurses and the management team on completing detailed assessments and clinical risk evaluations, such as the MUST assessment tool. This external refresher training is now completed since 31st December 2025. The current malnutrition risk assessment tools have all been reviewed to ensure that each MUST tool calculation is accurate.
Historical and irrelevant information within residents' care plans, including the use of falls diaries within care plans, has been removed. Registered nurses have been reminded and trained on the appropriate documentation to record incidents and ongoing monitoring, ensuring that care plans are used solely to guide the delivery of care based on residents' current assessed needs.
Internal management systems have been strengthened through a review and enhancement of the existing care plan audit tool and ir now includes the findings from the inspection to support early identification of risks, prevent recurrence, and ensure care plans remain current, evaluative, and person-centred.
Revised care plan audits will be completed on a bi-monthly basis in each house, using an appropriate sampling of residents' care plans within each house.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/01/2026
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	31/01/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Substantially Compliant	Yellow	31/12/2025

	that the service provided is safe, appropriate, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	31/12/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/12/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/01/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Not Compliant	Orange	31/01/2026

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			