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:	Croft Nursing Home
Name of provider:	Croft Nursing Home Limited
Address of centre:	2 Goldenbridge Walk, Inchicore, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	24 March 2026
Centre ID:	OSV-0000028
Fieldwork ID:	MON-0049951

About the designated centre

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

The Croft Nursing Home is located just a few miles from Dublin city centre and within walking distance of Inchicore village. The home is a single-storey building providing accommodation for 36 long stay beds. Accommodation is configured to address the needs of all potential residents and includes superior single, companion and shared accommodation with assisted bath and shower rooms. There are a number of lounges and reading areas located throughout the building. The centre also has access to a secure garden area for residents to use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	35

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 24 March 2026	09:10hrs to 16:10hrs	Marguerite Kelly	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day. Over the course of the inspection the inspector spoke with residents and staff to gain insight into what it was like to live in Croft Nursing Home. The inspector spent time observing the residents daily life in the centre in order to understand the lived experience of the residents. Those spoken to were generally positive about their experience of living in Croft Nursing Home and were complimentary of the service they received. One resident informed the inspector that 'the staff are lovely'. Another said 'I have no problems at all, but would love my own bedroom''. This request was also mentioned by another resident. All of the residents spoken to said the food was good and there was always a choice. There were no visitors seen during the hours of inspection.

There were residents who were living with a diagnosis of dementia or cognitive impairment who were unable to express their opinions on the quality of life in the centre. However, those residents who could not communicate their needs appeared comfortable.

On arrival the inspector was greeted by the Person in charge (PIC) and together they had a walk around the centre, giving an opportunity to meet with residents and observe their living environment.

The person in charge worked full time and displayed good knowledge of the residents' needs and had a good oversight of the service. The person in charge was well known to the residents. Residents were observed sitting in communal rooms, walking along corridors and some residents remained in their bedrooms.

Croft Nursing Home is a single storey premises located in Inchicore, Dublin 8 and is registered to provide care for 36 residents. Bedroom accommodation comprises of 11 twin bedrooms and 11 single bedrooms and one triple bedroom. Residents had access to a garden and patio area at the rear of the premises where patio seating was provided which allowed residents to sit and enjoy the outdoors.

Residents' bedrooms that were viewed by the inspector appeared clean, contained storage, and decorated with personal items. However, two en-suites seen by the inspector were not clean and one had a broken toilet seat resting behind the toilet. The failure to maintain clean en-suites and the presence of broken fixtures can create a risk of cross infection and the ability to perform effective cleaning.

Televisions, internet and call bells were provided in these bedrooms. The inspector noted that items of furniture, doors, and wall surfaces were scuffed and damaged. Because these surfaces are no longer smooth or impermeable, they cannot be effectively cleaned. The provision of suitable premises and infection control are

interdependent. These are similar findings to previous inspections held on Nov, 2024 and June, 2025.

There were a variety of activities for residents to choose from. All activities available were displayed on a notice board. During the day of the inspection several groups of residents were seen enjoying the daily activities.

Some residents were seen to take meals in the dining rooms, and others took meals in their bedrooms. The dining room was bright and well presented. Staff supported residents to get the meals and drinks of their choice. Some residents required support taking their meals, and this was provided by staff. The main kitchen was of adequate size to cater for resident's needs. Toilets and changing rooms for catering staff were in addition to and separate from care staff.

The centre provided a full laundry service for residents. Residents whom the inspector spoke with were happy with the laundry service. The laundry worker demonstrated a good knowledge of laundry processes, specifically regarding the correct washing and disinfection temperatures and the segregation of linen types. The laundry room's small footprint made the functional separation of clean and dirty phases difficult creating a risk of cross-contamination between soiled and processed linens. There was no flat surface within the laundry to allow for sorting out clean laundry. Additionally, the sink available for hand washing was not compliant with HBN 00-10 Part C standards. The presence of an incorrect drain, overflow and manual taps, creates a reservoir for bacterial biofilms and increases the risk of re-contaminating hands during the washing process.

There was a dirty utility room (a dedicated room used for the reprocessing and disposal of items contaminated with body fluids) with a functioning washer/disinfector. Both the floor and the drip tray for the storage and air drying of commode pans and urinals were not clean. This can increase the risk of cross-contamination, as these surfaces act as a reservoir for bacteria and can compromise the safety of the environment. Furthermore, the hand wash sink was not compliant and had exposed timber/chipboard around the sink stand. This was a repeat finding from a previous inspection in June 2025.

The hand wash sink in the dirty utility failed to provide hot water upon testing. Without correct water temperature, effective hand hygiene is compromised, and the risk of biofilm development in the 'cold' hot-water pipes is increased. Immediate remedial plumbing works were requested by the PIC and the centres plumber had resolved the issue before the inspector finished the inspection.

The inspector found that the facilities provided for housekeeping posed a risk of cross infection. Specifically, there was no dedicated hand-wash sink available within the housekeeping room to facilitate staff hand hygiene after handling contaminated items. Furthermore, the room lacked a dedicated janitorial unit or a bucket-fill station. This deficit meant there were no appropriate facilities for the safe preparation of cleaning chemicals or the sanitary disposal of waste water. The inspector was informed that a resident shower room was being utilized for housekeeping functions, including the preparation of equipment and the disposal of

waste water. This practice is inappropriate as it involves the use of a resident's personal hygiene area for janitorial tasks, failing to ensure clean environment and compromising the dignity of the residents' living space.

There was no lockable metal chemical store provided within this room for the safe storage of cleaning agents and the use of exposed untreated timber for shelving is an infection control risk, as porous surfaces cannot be effectively cleaned.

While alcohol hand gel dispensers were installed along the corridors, alcohol gel was not available at the point of care. This limits staff's ability to perform timely hand hygiene and can increases the risk of health care-associated infection (HCAI).

Although hand-wash sinks were available, they did not meet the HBN standards. Specifically, the sinks lacked clinical features (such as no overflows, compliant tap sets and correct position of drainage hole). These findings were similarly noted in previous inspection June 2025.

The centre lacked a dedicated clinical room, with the storage and preparation of medications and sterile supplies being shared with general office functions. This arrangement is inappropriate as office equipment and paper storage generate environmental dust and contaminants that compromise the integrity of sterile items. There was no hand hygiene sink within this room to enable staff to clean their hands at the point of medication preparation or preparing for wound dressings. The inspector acknowledges the presence of a hand-wash sink located outside the room. However, this arrangement is not compliant with Health Building Note 00-09: Infection control in the built environment.

The next two sections of the report present the findings of this inspection in relation to the governance and management of infection prevention and control in the centre, and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This inspection had a specific focus on the provider's compliance with IPC oversight, practices and processes.

The Inspector followed up on the provider's progress with completion of the infection prevention and control related actions detailed in the compliance plan from previous inspections. While efforts to improve the centre's facilities through general maintenance such as repainting and the replacement of some furniture were noted, these measures did not address the infrastructural deficits noted on the day of

inspection and infection control risks that remain outstanding from previous inspections. Regulation 17 (Premises), Regulation 23 (Governance and management) and Regulation 27 (Infection Control) remain in breach of the regulations.

Following the inspection in November 2024, the registered provider had committed to reconfiguring the triple occupancy room, which was complete. The provider has also ensured that lockable storage is now available to all residents within their bed space.

Due to the significant concerns about the centre, and repeated findings a warning meeting was held where the provider was informed that escalation measures will be taken, which may include the attachment of additional conditions to the registration of Croft Nursing Home should compliance with the Health Act 2007 not be achieved in a timely manner to ensure the safety and well-being of residents in the centre.

Croft Nursing Home is operated by Croft Nursing Home Limited and is the registered provider of this designated centre and is part of the wider Silver Stream Health Care Group who operates a number of other designated centres nationally. The person in charge is supported in their role by an assistant director of nursing and two clinical nurse managers. There is a senior management team in place to provide management support at group level. A local team of staff nurses, health care assistants, and activities, administrative, catering and domestic personnel complete the complement of staff supporting residents in the centre.

On the day of inspection, there appeared to be sufficient nursing and care staff to meet the needs of the residents. This finding was reinforced by feedback from residents spoken with.

While two housekeeping staff were on duty during the inspection, the environmental hygiene deficits observed across several areas indicated that these staffing resources were not being effectively managed. Notably, these are recurring findings from both June 2025 and September 2025 inspections, demonstrating that the provider's previous compliance plan and internal monitoring systems were not fully effective in identifying the specific hygiene deficits noted on the day of inspection.

The person in charge had been nominated to the role of infection prevention and control link practitioner to support staff implement effective infection prevention and control and antimicrobial stewardship practices within the centre. They had completed the link practitioner training. They demonstrated a commitment and interest for their role. For example, in completing regular IPC audits and providing support to the staff team.

The quality and safety of care was being monitored through a schedule of audits including infection prevention and control. The Quarter 1 2026 IPC audit captured some of the findings seen on the day of inspection. For example; a broken clinical waste bin pedal bin in the dirty utility was faulty and outside clinical waste bins were not covered. These were still evident on the day of inspection.

The registered provider ensured there was a structured effective communication system in place between clinical staff and management that included daily handover meetings, clinical governance meetings and regular staff meetings. Meeting records included improvement actions and the responsible person whose duty was to address the areas for attention.

The provider had implemented a number of *Legionella* controls in the centres water supply. For example, infrequently used outlets and showers were run weekly. Documentation was available to confirm that the hot and cold water supply was routinely tested for *Legionella* to monitor the effectiveness of controls.

A review of notifications submitted to HIQA found that outbreaks were documented in a timely and effective manner. The centre had experienced one respiratory outbreak in January 2026.

Regulation 15: Staffing

The skill-mix and number of staff on duty were adequate to ensure that residents needs were met. There was at least one registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

There was an ongoing schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles. Both local and national IPC policies were available to guide and support staff.

The inspector noted that staff appraisals were in place, supporting a culture of continuous professional development and accountability.

Judgment: Compliant

Regulation 23: Governance and management

While there were systems in place to oversee the clinical and social care of the residents, the systems for the oversight of aspects of the premises and the maintenance of the residents' environment were not in place. This was evidenced by;

- Management systems in place did not ensure that the cleaning procedures and maintenance in the centre were completed to the recommended standards to protect residents from infection. For example:
    - Unclean floors in dirty utility and store room and unclean drip tray in dirty utility.
    - Two ensuites seen not clean and broken toilet seat placed behind toilet. This is a repeat finding.
- The auditing process did not identify and action deficits in relation to the premises and infection control risks. This is a repeat finding.
- Actions committed to in a previous inspection compliance plans dated June 2025 were not completed. For example;
    - Paintwork was still seen to be chipped on some walls and door frames
    - Hand wash sinks remain non-compliant to HBN 00-10 standards
    - The hand washing sink in the dirty utility is not compliant and remains on a surround which cannot be effectively cleaned. These are repeat findings.

Judgment: Not compliant

Quality and safety

Overall, residents spoken with said they had a good quality of life. Residents lived in an unrestricted manner according to their needs and capabilities. There was a focus on social interaction and residents had opportunities to participate in group or individual activities.

Residents were consulted with regarding the running of the centre through regular residents' meetings which were well attended by the residents. From a review of minutes of these meetings, it was evident that issues such as food and activities were discussed. Action plans were completed.

The centre had arrangements in place to ensure that visiting was not restrictive. Residents were able to meet with visitors in private or in the communal spaces throughout the centre. Residents had timely access to their general practitioners (GPs) and specialist services such as tissue viability and physiotherapy as required. Residents also had access to other health and social care professionals such as speech and language therapy, dietitian and chiropody.

Resident care plans were accessible on a computer based system. Pre-admission IPC assessments and four-monthly reviews were undertaken, documentation for catheter care were descriptive and gave a clear record of insertion dates, bag changes, and specific monitoring required to mitigate the risk of catheter-associated urinary tract infection.

Notwithstanding the positive elements of some of the clinical documentation, the care plan for a resident with a Multi-Drug Resistant Organism (MDRO) was inconsistent with national guidelines. This may pose a risk of cross-infection to other residents within the shared environment.

The inspector identified some examples of good antimicrobial stewardship. The volume of antibiotic use was also monitored each month. Staff had received training on the "skip the dip" campaign which aimed to prevent the inappropriate use of dipstick urine testing that can lead to unnecessary antibiotic prescribing.

Surveillance of health care-associated infection (HCAI) and multi-drug resistant bacteria colonisation was routinely undertaken and recorded. Documentation reviewed identified some examples of antimicrobial stewardship practice in order to improve antimicrobial use and combat antimicrobial resistance.

The provider had access to diagnostic microbiology laboratory services and a review found that clinical samples for culture and sensitivity were sent for laboratory analysis as required. A dedicated specimen fridge for the storage of samples awaiting collection was available. However, it was not clean. Medical fridges must be maintained in a clean condition to prevent the growth of bacteria and the risk of cross-contamination between clinical samples.

The inspector identified some examples of good practice in the prevention and control of infection. For example, staff applied standard precautions to protect against exposure to blood and body substances during handling of waste and used linen. Appropriate use of personal protective equipment (PPE) was also observed during the course of the inspection.

Regulation 17: Premises

Action is required to ensure compliance with regulation 17 and the matters set out in Schedule 6 to ensure that the premises promotes a safe and comfortable environment for all residents.

Several areas were not kept in a good state of repair, for example;

- The store room floor was unclean and contained a mix of resident equipment, clean laundry, sterile supplies and nutrition drinks. This lack of functional separation poses a risk of cross-contamination, as sterile items and food products were stored in close proximity to communal equipment.
- The dedicated housekeeping room for storage and preparation of cleaning trolleys and equipment did not have access to running water, mop bucket station, hand wash sink, chemical storage cupboard and contained untreated timber.
- The laundry room's small footprint made the functional separation of clean and dirty phases difficult creating a risk of cross-contamination between soiled and processed linens. There was no flat surface within the laundry to

allow for sorting out clean laundry. Additionally, the sink available for hand washing was not compliant with standards.

- The centre lacked a dedicated clinical room, with the storage and preparation of medications and sterile supplies being shared with general office function. There was no hand hygiene sink within this room to enable staff to clean their hands.
- The Hand-wash sinks available did not meet the HBN 00-10 Part C Sanitary Assemblies standards. Specifically, the sinks lacked required clinical features (such as no overflows, compliant tap sets and correct position of drainage hole). These findings were similarly noted in previous inspection June 2025. This is a repeated finding.
- Storage of resident items such as continence wear were stored outside in an single layer non- insulated shed, which was not secure from pests or weather as visible daylight was apparent around the edges. This poses a risk to the integrity and hygiene of the supplies stored in here. This is a repeat finding from June 2025.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

Where the resident was temporarily absent from the designated centre, relevant information about the resident was provided to the receiving designated centre or hospital. Copies of transfer letters when residents were temporarily transferred to hospital were maintained on the resident's file or electronic care record.

When residents returned from the hospital, relevant information regarding MDRO history was documented on the transfer form.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy and risk register in place which identified hazards and control measures for the specific risks outlined in the regulations. Arrangements for the investigation and learning from serious incidents were in place and outlined in the policy.

Judgment: Compliant

Regulation 27: Infection control

The provider failed to meet the requirements of Regulation 27 (Infection Control) and the National Standards for Infection Prevention and Control in Community Services (2018). This was evidenced by the following:

- Sharps boxes were seen with temporary closure mechanism in place, but not signed on assembly. This lack of documentation hinders effective traceability and audit of clinical waste management.
- Single use wound dressings and solutions were seen open and partially used. This may impact the sterility and efficacy of these products.
- Health care risk waste pedal bin in the dirty utility was not functioning correctly.
- External Health care risk waste bins were left open and unsecured. This practice is inconsistent with national HPSC guidelines for the safe management of healthcare risk waste and poses a risk of unauthorized access and environmental cross-contamination.
- While alcohol hand gel dispensers were installed along the corridors, Alcohol gel was not available at the point of care. This deficit limits staff's ability to perform timely hand hygiene.
- The specimen fridge available was not clean. Medical fridges must be maintained in a clean condition to prevent the growth of bacteria and the risk of cross-contamination between clinical samples.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Assessments were completed for residents on or before admission to the centre. Care plans based on assessments were completed no later than 48 hours after the resident's admission to the centre and reviewed at intervals not exceeding four months. Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents.

Judgment: Compliant

Regulation 6: Health care

Records showed that residents had access to medical treatment and expertise in line with their assessed needs, which included access to a range of health care specialists.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider ensured residents were consulted about the management of the designated centre through participation in residents meetings. Residents also had access to an independent advocacy service.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Croft Nursing Home OSV-0000028

Inspection ID: MON-0049951

Date of inspection: 24/03/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

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

The Registered Provider acknowledges the repeated findings and assures that strengthened governance systems, oversight structures, and accountability measures are being implemented to ensure the service is safe, effectively monitored, and that all identified risks are addressed in a timely and sustainable manner.

• The Person in Charge (PIC), supported by the ADON, will complete weekly environmental walks to identify risks, ensure timely action, and monitor standards until safe practices are maintained.
• A comprehensive audit programme has been enhanced to ensure environmental hygiene, maintenance, and IPC risks are identified and actioned promptly. This complements and provides oversight of existing external audits.
• A centralised action tracking system has been introduced to record all audit findings, with each action assigned to a responsible person and a defined timeframe. Progress is monitored weekly by the PIC, in collaboration with the Estates and Engineering Manager, until completion. This will support the team in addressing repeat findings and ensuring sustained compliance.
• Findings from audits, IPC walkarounds, and environmental checks are also reviewed at Monthly Governance and Facilities meetings, with clear documentation of actions, responsible persons, and follow-up to ensure accountability and continuous improvement.
• Staff awareness and accountability have been reinforced through huddles, supervision, and training, ensuring all staff understand their roles in maintaining a safe environment and adhering to IPC standards.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider acknowledges the repeated findings and assures that enhanced governance, oversight, and resource allocation are in place to ensure full and sustained compliance.

• A comprehensive premises upgrade plan has been developed to address identified deficits and ensure compliance with Schedule 6 requirements. Priority actions include:
o Non-compliant hand-wash sinks will be replaced or upgraded in line with HBN 00-10 standards where feasible, with risk assessments and mitigating controls maintained for areas where replacement is not currently achievable.
o Reconfiguration of the housekeeping room to include a janitorial sink and a dedicated hand-wash sink, mop bucket station, and secure chemical storage.
o Reconfiguration of nurses' office to develop of a dedicated clinical area for safe storage and preparation of medications and sterile supplies.
• Immediate actions have been implemented:
o Deep cleaning and reorganisation of the store room to ensure segregation of equipment, sterile supplies, and nutritional products.
o Removal of inappropriate storage practices and implementation of clear assigned areas and labelling systems.
• A plan is in place to address laundry workflow risks to ensure separation of clean and dirty processes. Risk Register has been updated to reflect these risks and control measures. Current work practices, including the use of a mobile trolley for sorting, are preferred by staff due to the flexibility they provide within the available space. These practices are being reviewed to ensure they align with infection prevention and control requirements.
• The external storage unit for continence wear is being reviewed to ensure it is secure, insulated, and pest-proof, in order to maintain product integrity.
• A rolling maintenance programme is in place to repair damaged surfaces (walls, doors, furniture) to ensure all finishes are smooth, sealed, and cleanable.
• All works are scheduled with defined timelines and are being monitored by the PIC and Estates & Engineer Manager, with progress reviewed monthly until completion.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

The Registered Provider acknowledges the findings and assures that strengthened infection prevention and control systems, oversight, and staff practices are in place to achieve and maintain compliance.

• Immediate corrective actions have been completed:
o Removal and replacement of open or partially used single-use items.
o Cleaning and decontamination of the specimen fridge, with implementation of a cleaning schedule and daily temperature/cleanliness checks.
o Repair/replacement of faulty clinical waste bins and securing of all external healthcare risk waste bins in line with national guidelines.
• Alcohol hand gel availability at point of care has been addressed through installation of additional dispensers and implementation of daily stock checks.
• A clinical waste management audit, incorporated into the IPC audit, is now conducted monthly (increased from quarterly) until sustained compliance is achieved. This ensures correct assembly, labelling, and traceability of sharps containers.
• IPC practices have been reinforced through targeted staff training sessions. Compliance will be monitored through monthly IPC audits and regular observational spot checks.
• Enhanced environmental cleaning protocols have been implemented, including increased frequency in high-risk areas (sluice room, clinical equipment), with clear accountability and audit trails.
• Weekly supervision visits by the external housekeeping contractor supervisor are in place. Findings are discussed at the time with Management in the home and escalated to Estates & Facilities Manager as appropriate.
• The IPC link practitioner (PIC) will lead weekly IPC walkarounds, ensuring early identification and escalation of risks, with findings discussed at staff meetings, Health & Safety meetings and Clinical Governance meetings.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	13/05/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the	Not Compliant	Orange	13/05/2026

	Authority are in place and are implemented by staff.			