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:	Greenhill Nursing Home
Name of provider:	Saivikasdal Ltd
Address of centre:	Waterford Road, Carrick-on-Suir, Tipperary
Type of inspection:	Unannounced
Date of inspection:	01 April 2026
Centre ID:	OSV-0004584
Fieldwork ID:	MON-0049942

About the designated centre

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

Greenhill Nursing Home is situated in a residential area approximately half a mile from the centre of Carrick-on-Suir on the main Waterford road. Local amenities are all within easy access of the centre. The registered provider of the centre is Saivikasdal Ltd, and Greenhills Nursing Home is purpose-built, and residents' accommodation comprises single bedrooms and one twin bedroom, most with en suite facilities. The layout of the centre comprises of three wings, each with its own large day room. Day rooms are arranged with a comfortable lounge area and a dining area. The main dining room is located by the main reception. This is a large room with views of the enclosed landscaped garden. Residents have access to the garden via many exits. The garden has walkways, seating areas, a smoking shelter, and raised flower and vegetable beds for residents' enjoyment. Greenhills Nursing Home provides accommodation for 55 residents. The centre employs approximately 49 staff, and full-time nursing care is provided for both male and female residents with low to maximum dependency. It caters for long-term care, convalescence care and people with a diagnosis of dementia.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	51

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 1 April 2026	08:15hrs to 17:40hrs	Bernadette McDonald	Lead
Wednesday 1 April 2026	08:15hrs to 17:40hrs	Mary Veale	Support

What residents told us and what inspectors observed

Over the course of the day, the inspectors spoke with 15 residents and met two visitors during the inspection. Residents were mostly complementary of the centre, the staff, the quality of the care and activities provided. The inspectors spent time observing the environment, interactions between residents and staff, and reviewing various documentation. All interactions observed were person-centred and courteous. Staff were responsive and attentive without any delays while attending to residents' requests and needs.

There were 51 residents living in the centre on the day of the inspection. The premises are set out over three wings, "A Wing", "B Wing", and "C Wing". The centre's design and layout supported residents in moving throughout the centre, with wide corridors, sufficient handrails, furniture and comfortable seating in the various communal areas. The communal areas included a large dining room accessible from the main reception area and three smaller day rooms on each wing. The centre was seen to be suitably decorated throughout with paintings and pictures. Parts of the centre, in particular areas of "B Wing & C Wing", were observed to be unclean on the day of inspection. This is discussed further in this report under Regulation 27: Infection control.

Bedroom accommodation consists of 53 single bedrooms and one twin bedroom. The bedrooms of B Wing and C Wing have en-suite facilities that include a shower, toilet, and wash hand basin. The 13 single bedrooms on A Wing contain a wash hand basin and access to shared toilet and shower facilities. Bedroom accommodation throughout the centre included a television, a call-bell system, a wardrobe, and seating. Most bedrooms were personalised and decorated in accordance with residents' wishes.

Residents had access to a large enclosed rear garden and external grounds to the front of the premises. The garden had level paving, mature scrubs and comfortable seating. Residents had access to a designated smoking area in the enclosed rear garden. Residents who were observed to access the enclosed secure rear garden had their access restricted due to the use of a door alarm. This is discussed further under Regulation 9: Residents' rights.

Residents were complimentary of the home-cooked food and the dining experience in the centre. Residents stated that there was always a choice of meals, and the quality of food was excellent. The daily menu was displayed in the dining room. There was a choice of two options available for the main meal. Jugs of water and cordial were available for residents. The inspectors observed snacks being offered to residents outside of meal times.

The centre provided a laundry service for residents. All residents whom the inspectors spoke with on the day of inspection were happy with the laundry service.

Residents' spoken with said they were very happy with the activities programme in the centre, and some preferred their own company but were not bored as they had access to newspapers, books, radios, the internet and televisions. The activities programme was displayed on the notice board near the reception area. The inspectors observed residents attending mass in the dining room in the afternoon. Residents' views and opinions were sought through resident meetings and satisfaction surveys, and they felt they could approach any member of staff if they had any issue or problem to be solved. Residents had access to advocacy services.

Friends and families were facilitated to visit residents, and the inspectors observed many visitors in the centre throughout the day. Visitors who spoke with the inspectors were happy with the care and support their loved ones received.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

This inspection was a one day unannounced inspection conducted by two inspectors to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres) Regulations 2013 to 2025 (as amended). The inspectors followed up on the compliance plan submitted by the provider following the inspection of the centre in September 2025, on statutory notifications and on one piece of unsolicited information submitted to the office of the Chief Inspector of Social Services. This information was used to support the development of lines of enquiry for this inspection.

The findings of this inspection were that the provider had not ensured that management systems and oversight of the services were consistently and effectively implemented to ensure the premises were cleaned, maintained and utilised to an adequate standard, and that the residents had a choice in their daily lives. Therefore, further measures were required by the provider to comply with regulatory requirements in respect of governance and management, infection control, care planning, residents' rights, training and staff development, premises, the directory of residence and medication management.

Saivikasdal Limited is the registered provider for Greenhill Nursing Home. The company had two directors, one of whom is engaged in the day-to-day oversight of the service. The management structure within the centre was clearly defined, and staff were all aware of their roles and responsibilities. The person in charge was supported by a director of clinical care quality and standards. The person in charge

worked full-time at the centre and was supported by an assistant director of nursing, a team of nurses and healthcare assistants, an activities co-ordinator, housekeeping, catering, administration and maintenance staff.

From a review of the staff roster and communication with staff and residents, the inspectors found that, in general, the service had appropriate staffing numbers in place to meet the needs of the 51 residents living in the centre, on the day of inspection.

Staff had access to relevant training, and the registered provider had a robust oversight system in place to ensure all staff training was up to date. New employees were supported in their roles through a comprehensive induction programme. All staff had a written record of induction kept on file. Notwithstanding this, inspectors observed that staff were not appropriately supervised, as their infection control practices were not in line with best practice. This is further discussed under Regulation 16: Training and staff development and Regulation 27: Infection control.

A directory of residents was available for inspectors to review. Areas for improvement were identified and will be discussed under Regulation 19: Directory of residents.

The inspectors viewed records of governance meetings, and staff meetings that had taken place since the previous inspection. Regular governance meeting and staff meeting agenda items included key performance indicators (KPI's), training, fire safety, care planning, infection control and residents' feedback. There was an Infection and prevention control (IPC) policy available for staff, which included guidance on COVID-19 and multi-drug resistant organism (MDRO) infections.

There was evidence of an ongoing schedule of audits in the centre, for example; in relation to care planning, infection prevention and control, restrictive practice and medication management. IPC audits included the environment and antibiotic usage review. Findings of audits did not have any action plans developed and did not show any evidence of quality improvement strategies or follow-up reviews. This is discussed further under Regulation 23: Governance and management.

A detailed annual review of the quality and safety of care delivered to residents took place in 2025 in consultation with residents and their families. Residents and families had been consulted in the preparation of the annual review through surveys and the residents' committee meetings. Within this review, the registered provider had also identified areas requiring quality improvement in 2026.

Complaints were found to have been managed in line with the centre's own policy and the regulations. The complaints officer had not completed training in complaints on the day of inspection, but had done so after inspection and submitted evidence of this to the office of the Chief inspector of Social services.

Regulation 15: Staffing

On the inspection day, staffing was found to be sufficient to meet the needs of the residents. There was a minimum of two registered nurses on duty in the centre at all times.

Judgment: Compliant

Regulation 16: Training and staff development

This inspection found that further supervision was required in infection prevention and control procedures, as staff practices did not consistently adhere to best-practice guidelines to ensure that residents were protected from the risk of infection, as detailed under Regulation 27: Infection control.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents did not contain all the information as required under Schedule 3 of the regulations. For example:

- Where a resident was transferred to a hospital, the name of the hospital and the date of transfer were not recorded.
- Residents' religion and marital status were not recorded in a large number of entries.
- Inconsistencies in the recording of general practitioner (GP) details and next of kin information were consistent throughout the directory.
- The cause and time of death were not recorded for a number of entries.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems in place did not fully ensure that the service provided was effectively monitored. For example:

- While an ongoing continuous cycle of audits was conducted to monitor the quality of care delivered, the actions identified from some audits were not specific enough to drive quality improvement on a system-wide level. A

sample of observations of care audits viewed, recorded repeated negative findings, and there was no corrective action plan developed.
- Systems of communication were not sufficiently robust, as minutes of staff meetings were notes which did not include an action plan for items requiring action to ensure cascading of the governance structure to drive quality improvement.

These were repeated findings following the September 2025 inspection.

- Further oversight was required of issues pertinent to premises and infection prevention and control, as outlined further under the relevant regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a policy in place for dealing with complaints, which included a review process. The policy was displayed in a prominent position throughout the centre. A sample of six complaints was reviewed, and complaints were found to be in line with the centre's own policy and requirements of the regulations. Complainants were provided with a written response to their complaint within the required time frames, and residents spoken with on the day of inspection understood what to do if they wished to make a complaint.

Judgment: Compliant

Quality and safety

The inspectors found that the staff working in the centre, in general, were delivering a good standard of nursing care. However, gaps in oversight of governance and management were impacting on the quality of life and the safety of the residents.

There was a policy on end-of-life care. The centre had established links with the general practitioner (GP) and palliative care teams to ensure all comfort measures are in place for residents requiring end-of-life care.

The design and layout of the centre were generally suitable for its stated purpose and met residents' individual and collective needs in a homely way. The centre was found to be inviting and pleasantly decorated to provide a homely atmosphere. Bedrooms were personalised, and residents had space for their belongings. The centre had a well-maintained enclosed rear garden. There were comfortable and pleasant communal areas for residents and visitors to enjoy. However, inspectors

identified that some parts of the premises did not meet the requirements of Schedule 6 and this is discussed in this report under Regulation 17: Premises.

Hand-sanitiser dispensers were conveniently located in all corridors to facilitate staff compliance with hand hygiene requirements. Personal protective equipment (PPE) stations were available on all corridors to store PPE. Used laundry was segregated in line with best-practice guidelines, and the centre's laundry had a workflow for dirty-to-clean laundry, which prevented the risk of cross contamination. Regardless of some good practices, a number of areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018), as discussed under Regulation 27: Infection control.

Residents on modified diets had their medications administered in an appropriate form, and medications were seen to be administered within recommended time frames. Medicines controlled by the misuse of drugs legislation were stored securely, and balances were checked by staff nurses twice daily. The inspectors reviewed balances of a sample of controlled drugs, which were seen to be correct. Medicines that were out-of-date were stored in a secure manner away from other medicinal products. Residents were afforded the choice of a pharmacist on admission to the centre. However, inspectors identified gaps in the nurses' signing off on both controlled medications and regularly prescribed medications on residents' drug records. This is further discussed under Regulation 29: Medicines and pharmaceutical services.

The inspectors reviewed a sample of residents' records and care plans. While they were reviewed on a four-monthly basis, further improvements were required to ensure that they were person-centred and updated to guide safe and effective care. Details are presented under Regulation 5: Individual assessment and care plan.

The health and well-being of residents were promoted, and residents were given appropriate support and had access to health care professionals to meet any identified health care needs. Residents who required assistive equipment to mobilise were found to have access to the appropriate aids to promote their independence. Inspectors also found that residents were supported to access health screening services under the National Screening Service.

Staff demonstrated appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All interactions between staff and residents were observed to be respectful throughout the inspection. Residents reported that they felt safe living in the centre. The provider was not acting as a pension agent for any residents living in the centre. The provider had a transparent system in place where all lodgements and withdrawals of residents' personal monies were signed by two staff members and logged. The provider also audited the balances on a regular basis in line with the centre's policies.

Residents had the opportunity to meet together and discuss relevant issues at resident committee meetings in the centre. An activity schedule was available with an activities programme provided from Monday to Sunday. Residents had access to

an independent advocacy service. Residents have access to daily national newspapers, books, televisions, and radios. A Mass and a rosary recital took place weekly at the centre, which residents said they enjoyed. However, inspectors observed that residents' rights to privacy were not always supported in the centre, and this is discussed under Regulation 9: Residents' rights.

Regulation 13: End of life

The inspectors reviewed individual care records relating to their end-of-life care needs and found that their expressed wishes were clearly documented which outlined their physical, emotional, social and spiritual preferences.

Judgment: Compliant

Regulation 17: Premises

While the premises were designed and generally laid out to meet the number and needs of residents in the centre, some areas required review to be fully compliant with Schedule 6 requirements, for example:

- General wear and tear was observed on door frames throughout the centre.
- Call-bell devices required review, as some call-bell attachments were missing from a number of communal rooms.
- Inspectors observed inappropriate storage of equipment in residents' en-suites, for example, commodes and wheelchairs.
- Areas of the flooring were damaged and had paint marks throughout the centre.
- A window restrictor was observed not working in the visitors' room, which could potentially pose a risk of a resident exiting through this window.

Judgment: Substantially compliant

Regulation 27: Infection control

Action was required to ensure residents were protected from the risk of infection and to comply with the National Standards for Infection Prevention and Control in Community Services (2018). The environment and equipment were not managed in a way that promoted good infection control practices. Areas of the centre were not cleaned to an acceptable standard. Examples include;

- Unclean urinals were observed in residents' bedrooms, and some were not emptied in a timely manner, leading to odours of urine and possible spillage of the contents of the urinals.
- Unclean urinals in sluice rooms posed a risk of cross-contamination with clean equipment and the spread of infection.
- There was an odour of urine, particularly in A wing and B wing, causing an uncomfortable environmental odour for residents.
- There was inappropriate storage of wash-hand basins, bedpans and urinals.
- Toilet cleaning equipment was observed to be unclean.
- The underside of some shower chairs was observed to be unclean.
- The deep cleaning schedule showed that some scheduled cleaning had not occurred.

The effects of the above pose a risk of cross-contamination between residents.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors observed examples where medication administration and storage practices did not align with best practice and professional guidelines issued by An Bord Altranais agus Cnáimhseachais. The following findings posed a risk to residents' safety;

- Inappropriate storage of medical products such as medicated creams on residents' lockers or en-suites. This posed a risk of ingestion of the creams or over-application of the creams by residents.
- Gaps in administration entries for prescribed medications and some controlled drugs not signed for on the drug kardex. This is not in line with the best practice.
- A drug trolley was observed to be left unlocked and unattended in the day room in C Wing. This posed a significant risk to residents' safety.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were not always developed following a comprehensive assessment of the residents' needs. For example;

- A resident who was assessed as having pain and was prescribed analgesia did not have a care plan developed to meet their needs.

- A resident who had diabetes did not have a care plan in place to guide staff on the parameters within which their blood glucose levels should be maintained, or the actions staff should take if this resident's blood glucose measurements were not within safe parameters. This posed a risk that this pertinent information would not be effectively communicated to staff.
- A resident with a wound had their care plan not updated to reflect changes in treatment advised by their GP, and as a result, there was a risk that the care being implemented by staff on the day of inspection was not in line with the treatment advised by their GP.

Judgment: Substantially compliant

Regulation 6: Health care

General Practitioners (GP's) routinely attended the centre and were available to residents. Health and social care professionals also supported the residents on site where possible and remotely when appropriate, for example the dietitian, and physiotherapist. There was evidence of ongoing referral and review by health professional as appropriate.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse, including staff training and an up-to-date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were not continuously upheld in the centre. For example;

- Residents' meetings were held every 2 months, but the minutes of the residents' meetings did not indicate the number of residents in attendance. This reflects a missed opportunity by the provider to show that residents are involved in the ongoing running of the centre.
- A box of shared clothing was observed on the trolley on Wing A and B on the morning of inspection. Inspectors were informed by staff that these items

were spare items of clothing for use by residents if needed. This practice reflects everyday work practices in the centre and is not in line with respecting residents' rights.

- Each time a resident exited the centre to gain access to the smoking area, an alarm sound was triggered to alert staff that a resident had accessed the area. This alarm sound was loud and was observed to interrupt the residents' daily activities and quiet time. It also did not support residents' rights for privacy.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Greenhill Nursing Home OSV-0004584

Inspection ID: MON-0049942

Date of inspection: 02/04/2026

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: Enhanced supervision arrangements have been implemented across the centre to ensure staff are appropriately supervised and that infection prevention and control (IPC) practices are consistently in line with best practice. The Person in Charge (PIC), Assistant Director of Nursing (ADON), and IPC Link Practitioners now provide daily oversight of staff practices, with a particular focus on adherence to IPC procedures. All staff have completed IPC refresher training, specifically addressing identified deficits including hand hygiene, the correct use of PPE, and environmental hygiene practices. Staff competency is assessed through regular hand hygiene and PPE audits, with immediate feedback and corrective actions implemented where required. A revised cleaning schedule has also been introduced to support improved practice and compliance. Housekeeping staff will be receiving a formal workshop on Cleaning practices by the Director of clinical Care quality and standards. These measures are monitored through ongoing supervision and monthly audits and will be reviewed to ensure sustained improvement by 31 July 2026.	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: A comprehensive review of the Directory of Residents has been completed to address gaps in required information under Schedule 3. Records relating to hospital transfers, including hospital name and date of transfer, along with residents' religion, marital	

status, GP details, next of kin information, and cause and time of death, are being updated and verified.
A clear process has been established whereby the nurse in charge is responsible for ensuring that all required information is accurately recorded at the time of admission, transfer, discharge, or death.
Weekly audits and spot checks by the ADON have been implemented to ensure completeness and accuracy of records.
All identified gaps will be addressed and the directory brought into full compliance by 15 July 2026, with ongoing monitoring thereafter.

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 systems within the centre have been strengthened to ensure effective oversight of the service and to address identified gaps in monitoring, audit follow-up, and communication.
The audit framework has been revised to ensure all audits clearly identify specific deficits and include detailed action plans with assigned responsibility and defined timeframes. A tracking system has been implemented to monitor progress and ensure timely completion of all actions.
Staff and governance meetings have been restructured to include formal agendas, detailed minutes, and clearly documented action plans, ensuring accountability and follow-up of all identified issues.
Regular review meetings are conducted by the PIC and ADON to monitor trends, address recurring issues, and support continuous quality improvement.
These governance arrangements are being implemented and will be fully embedded and operational by 31 August 2026.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A programme of works has been implemented to address the identified issues in relation to premises, including general wear and tear, call bell functionality, flooring, storage practices, and window safety.
General wear and tear to door frames and decorative finishes is being addressed through

a planned refurbishment programme. An external painting contractor has been engaged to complete large-scale works across corridors, bedrooms, communal areas, and doors. Works are scheduled to commence on 29 June 2026, with the first phase to be completed by 20 July 2026.
To ensure adequate call bell provision, an external communications contractor has been contracted to install a new wireless nurse call system throughout the centre. Installation commenced on 22 June 2026 and is expected to be completed within five days, following which all resident and communal areas will have fully operational call bell access. Functionality will be verified by the Facilities Manager and documented accordingly.
The inappropriate storage of equipment in residents' en-suite bathrooms was addressed immediately following the inspection. All items, including commodes and wheelchairs, have been removed and relocated to appropriate storage areas. Ongoing compliance is monitored through regular environmental audits conducted by the Person in Charge.
A full review of flooring has been completed, and replacement works in identified areas, including corridors, toilets, and administrative areas, commenced on 17 June 2026. A phased replacement programme for bedroom flooring has also been incorporated into the 2026 capital expenditure plan, with progress monitored by the Facilities Manager as part of the preventative maintenance programme.
The defective window restrictor identified in the visitors' room was repaired immediately following the inspection. The repair has been tested, confirmed to be fully operational, and recorded in maintenance records. Routine checks of window restrictors are now included in the preventative maintenance schedule.
These actions are being monitored through the centre's maintenance and governance systems and will ensure full compliance with Schedule 6 requirements.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A comprehensive infection prevention and control (IPC) action plan has been implemented to address deficits identified in environmental hygiene, equipment cleanliness, storage practices, and adherence to cleaning schedules.
Immediate actions included deep cleaning of all affected areas, replacement or decontamination of unclean equipment such as urinals and shower chairs, and re organisation of storage systems to minimise cross-contamination risks. Cleaning equipment has been replaced or cleaned to ensure it meets required standards.
The cleaning schedule has been reviewed and strengthened, with clear accountability assigned and daily oversight by the management team to ensure completion.
Enhanced supervision of staff practices is in place, supported by increased frequency of IPC audits, including environmental hygiene, equipment cleaning, and waste management. All staff have completed targeted IPC refresher training addressing identified gaps.
These corrective actions are being closely monitored and will be fully implemented and

evaluated for effectiveness by 31 July 2026.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Immediate corrective measures have been implemented to address identified risks in medication management practices, including unsafe storage, gaps in documentation, and unsecured medication trolleys.
All medicinal products are now stored securely in designated areas, and any medicines previously stored in residents' rooms have been removed. Nursing staff have been reminded of their responsibility to ensure all medication administrations, including controlled drugs, are accurately signed and recorded.
Protocols are reinforced to ensure that medication trolleys remain locked and supervised at all times.
All nursing staff have completed medication management refresher training, with ongoing supervision and regular audits conducted by the PIC and ADON to ensure compliance with best practice.
These measures are monitored through ongoing audits and will achieve full compliance by 31 July 2026.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
A full review of resident assessments and care plans has been undertaken to ensure they are person-centred and reflective of residents' assessed needs.
Care plans have been developed and updated to address identified gaps, including pain management, diabetes care, and wound management, ensuring that clear guidance is available to staff in line with clinical recommendations.
The ADON provides ongoing supervision and support to nursing staff to ensure consistency and quality in care planning.
Regular audits have been implemented to monitor compliance and support continuous improvement.
All care plans will be fully reviewed and aligned with residents' needs by 31 July 2026.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Practices within the centre have been reviewed to ensure that residents' rights, dignity, and privacy are consistently upheld. The use of shared clothing has been discontinued, and residents are supported to maintain their own personal clothing in line with dignity and respect.
Residents' meetings have been strengthened, with improved documentation now capturing attendance and demonstrating resident participation in decision-making processes.
The door alarm system is being addressed through the installation of a new wireless nurse call system across the centre. This system, currently being installed by an external communications contractor (commenced 22 June 2026, with completion expected within five days), will replace existing alert mechanisms and ensure that safety alerts are effective without causing unnecessary noise or disruption to residents. This approach aligns with environmental and safety improvements implemented under Regulation 17 and supports both resident safety and privacy.
Staff have received education on residents' rights, dignity, and person-centred care, and ongoing monitoring is in place through supervision and audits to ensure these standards are consistently maintained.
All actions will be fully implemented by early August 2026, with continuous oversight thereafter.

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	31/07/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2026
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	15/07/2026
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	Not Compliant	Orange	31/08/2026

	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.	Not Compliant	Orange	31/07/2026
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Not Compliant	Orange	31/07/2026
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.	Substantially Compliant	Yellow	31/07/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	06/08/2026