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:	Anna Gaynor House
Name of provider:	Our Lady's Hospice and Care Services DAC
Address of centre:	Our Lady’s Hospice & Care Services, Harold's Cross, Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	25 March 2026
Centre ID:	OSV-0000465
Fieldwork ID:	MON-0049967

About the designated centre

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

Anna Gaynor House is a designated centre in south Dublin city which provides full time nursing care and support for up to 89 adult male and female residents. Residents are supported in single, twin and triple occupancy bedrooms across four units in a single storey building. The service provides care primarily for residents who require a high level of care. The centre avails of modern resources to promote and provide appropriate care and facilities for its residents. Residents are supported by a team of qualified nursing and support staff with centre management based on-site. Residents living in this service have on-site access when required to clinical services including geriatrician, physiotherapist, dietitian and occupational therapist. The centre premises includes large communal living and dining areas as well as multiple external courtyards and gardens on the site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	81

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 25 March 2026	07:30hrs to 16:00hrs	Sarah Armstrong	Lead
Wednesday 25 March 2026	07:30hrs to 16:00hrs	Aoife Byrne	Support

What residents told us and what inspectors observed

This was an unannounced inspection, carried out over one day, by two inspectors. The inspectors met with many of the residents, who were living in the centre. The overall feedback from residents was that Anna Gaynor House was a nice place to live and that staff were kind and caring to residents. Feedback from visitors and staff was mixed.

On arrival, inspectors walked the premises and met both residents and staff. The inspectors saw a small number of residents up and dressed and ready for the days' activities. The majority of residents were in bed waiting on breakfast or were having their care needs attended to. The inspector observed that staff knocked on residents' bedroom doors before entering and were attending to residents' care in an unhurried and respectful manner. Interactions between staff and residents was observed to be polite and informed throughout the day. Staff were generally seen to have a good knowledge of the residents' individual needs and preferences and were often observed engaging in general conversation with residents.

Following the morning walkabout of the premises, an introductory meeting was held with the person in charge and director of nursing in the centre, where the purpose of the inspection was set out. The purpose of the inspection was to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the compliance plan received from the previous inspection which was held in May 2025, statutory notifications submitted by the provider, and unsolicited information received about the centre since the last inspection.

Although many good practices were observed in the centre, inspectors identified concerns in relation to daytime staffing levels, specifically in respect of Marymount unit, as most residents with high dependency needs resided on this floor. Many staff who spoke with the inspectors confirmed that staffing was an issue during the day and at night, with a reduction in staffing numbers in recent months, leaving staff under additional pressure. Feedback from visitors confirmed that there were issues in relation to staffing levels on Marymount unit. Visitors told inspectors that there was a lack of supervision of residents in communal areas in Marymount, which they attributed to staff being particularly busy due to the high dependency levels of residents on this unit. Visitors also told inspectors that there were times when staff were unable to assist residents with personal care needs, and as a result, residents were left waiting for assistance. This included delays in residents receiving support with their toileting needs. Visitors also gave feedback that there was insufficient staff supervision of communal spaces on St. Benedict's unit during the day. Some visitors were also unsatisfied with the communication from staff about the care that their relative received and the management of incidents in the centre.

Inspectors observed the meal time experience for residents and found this to be a social occasion. Residents had a choice of food options for lunch, which included chicken and pasta or beef and Guinness pie. For dessert, residents could choose between mousse and cheesecake. Residents told inspectors that the food was "very tasty" and when asked about the portion sizes, residents said "there's always plenty of food here". Some residents received tray service to their bedrooms at lunch times as per their requests. Other residents chose to dine in the social environment of the communal dining spaces. Some residents were observed to require support from staff with meals, and where this was the case, staff were seated next to the residents and assisting them in a calm and dignified manner whilst engaging in polite conversation. Tables were nicely set with cutlery and condiments and menus were available to assist residents in making a choice around their meal.

A programme of activities was available to residents, which was carried out by dedicated activity staff. The inspectors saw the schedule of activities was displayed on notice boards in each unit and in the main hallways. During the morning of the inspection many of the residents were in the main day room and were enjoying a lively exercise game. Other activities available on the day of inspection included playing the card game 'bridge' and one to one sessions. The pet therapy dog was also scheduled to visit residents in the afternoon. Residents also had access to other activities including poetry sessions, bingo, Sonas, storytelling, Tai Chi, Mens' Shed and quizzes, throughout the week. Residents who spoke with the inspectors gave high praise for the variety of activities available. A lot of residents spoken with were involved in the knitting group “Lets Get Hooked”, with a lot of their pieces displayed throughout the grounds such as; colourful knitted blankets wrapped around the trees along the avenue leading up to the centre. There was also an established residents' choir group "The Chancers" which residents told inspectors they enjoyed both participating in and listening to.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect 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

Overall, findings of this inspection were that residents received a good standard of care and quality of life. Following up on the compliance plan from the last inspection in May 2025, it was evident that actions were taken to come into compliance in some areas. However, improvements were required to the oversight of resources and staff practices to ensure the service was safe and effectively monitored. The inspectors reviewed examples of audits, including care plan audits, falls audits and call bell audits and found that whilst there was a schedule of audits taking place which identified areas for improvement, additional oversight was required to ensure

that there was sufficient resources available and that staff were being effectively supervised to ensure that recommendations made were implemented in practice. Inspectors reviewed a sample of staff meetings where staff were supported to raise concerns and found that not all staff were afforded equal opportunity to raise their concerns. Staff on Marymount unit were not given the same opportunity to provide their feedback, including feedback in respect of staffing levels. In addition, it was evident on the day that staff were under additional pressure, with residents having to wait for assistance from staff, and staff telling inspectors that they did not have sufficient time to update residents' care records due to their workload. These findings are discussed further under Regulation 23: Governance and management.

Our Lady's Hospice and Care Service DAC is the registered provider for Anna Gaynor House. There was a clearly defined management structure in place with responsibility for the delivery and monitoring of care to residents. The person in charge in the centre is also the assistant director of nursing. They are supported in their role by a director of nursing and a team of clinical nurse managers. A local team of staff nurses, health care assistants, activities coordinators, and administrative, catering and domestic personnel complete the complement of staff supporting residents in the centre.

Staff had access to a programme of training that was appropriate to the service provided. Staff training records confirmed that all staff were up-to-date with mandatory training modules, such as fire safety and safeguarding of vulnerable adults. Following the last inspection in May 2025, the registered provider had implemented positive improvements to ensure that all staff were provided with an opportunity for annual performance reviews to support them to develop within their roles. However, during the inspection, inspectors observed that on Marymount unit staff practices were not appropriately supervised. This is further discussed under Regulation 16: Training and staff development.

Records set out in schedule 2, 3 and 4 were kept in the designated centre and made available to the inspectors on the day of inspection. However, record management within the units required further oversight to ensure they were kept in a safe manner. For example, inspectors observed examples where medical record trolleys containing residents' personal information were left unlocked and unattended by staff. This is a repeat finding from the previous inspection and is further discussed under Regulation 21: Records.

There was a valid contract of insurance against injury to residents in place in the centre.

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. For example:

- One resident was recently assessed as being fully continent but requiring prompting with toileting. However, inspectors observed this resident to be wearing continence wear on the day of inspection. While inspectors were informed that the residents' needs had changed there was no evidence of this in the residents care plan.
- The rostering system for clinical nurse managers (CNM) on a high dependency unit did not ensure effective support or supervision of nursing and care staff on site. There was no CNM rostered on Marymount unit Monday to Friday each week. The CNM on this unit worked 3 long days per week and this was shown to have a negative impact on the supervision of staff to ensure they adhered to correct practices.
- Inappropriate staff practices which did not promote safe or consistent care were observed, for example:
    - Inappropriate storage of standing hoists in a shower room blocking access to a resident toilet.
    - Staff storing own belongings in a cleaners room.
    - Soiled linen stored with clean linen.

The registered provider had not ensured that staff were informed of the Health Act 2007 or the regulations made under it. Staff who spoke to the inspectors were not familiar with the Health Act 2007, or where to find a copy of the Act in the centre. Staff were unaware of how the regulations relate to the service they provide. This is a repeat finding.

Judgment: Not compliant

Regulation 21: Records

A sample of records including staff files and residents' records were reviewed, however not all records met the requirements of Schedule 2 of the regulations as follows;

- One staff member's file did not contain a full employment history including any gaps in employment.

Not all records were stored securely and therefore residents' personal information was easily accessible to unauthorised persons. This is a repeat finding. For example;

- Two medical record trolleys were left open and unattended.
- Clinical handovers, which contained confidential information about residents, were seen stored on shelves and left on the counter at nurse's stations.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had in place a contract of insurance against injury to residents, which was in date.

Judgment: Compliant

Regulation 23: Governance and management

Further action was required to ensure that all areas of the designated centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example:

- The oversight systems in place to ensure the allocation of staff was sufficient across all units to meet the level of care required was insufficient. This was evidenced by the allocation of resources on the Marymount unit. Inspectors found that this unit had a large number of high dependency residents, however the staffing levels were not consistently aligned with the assessed needs of the residents and to ensure that documentation relating to the resident was kept up to date.
- Visitors and residents told inspectors that, at times, there were delays in staff responding to their needs, including assisting with toileting, which they attributed to staffing levels.
- Inspectors were told by staff that gaps in documentation were due to the busy workload which was resulting in a lack of protected time for them to ensure records were kept up to date.

The management systems in place were not sufficiently robust to ensure that the service provided was consistent and effectively monitored. This included the oversight of assessments and care planning systems to ensure residents' current needs were accurately reflected in their health care records. This was evidenced by the following:

- The oversight systems in place to ensure the actions committed to in the compliance plan submitted following the previous inspection, specifically relating to care plans were insufficient which resulted in repeat findings under Regulation 5: Individual assessment and care plan.
- The systems in place to monitor the care provided to residents had not identified the gaps in safe management and storage of records, nor did it ensure that residents' records were kept up to date to ensure they reflected the current needs of residents.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents living in Anna Gaynor House were supported to enjoy a good quality of life, where their interests, personalities and wishes were respected and promoted by dedicated staff. Staff were seen to know and understood the residents' personalities well. Feedback from residents about the service they received was positive.

In general, the premises was designed and laid out to meet the needs of residents living in the centre. The centre was warm, with plenty of natural light and was observed to be clean on the day of inspection. Residents' bedrooms were furnished with their personal belongings and residents spoken with told inspectors they liked their rooms. There was plenty of suitable communal space for residents, and these spaces were observed to be used by residents throughout the day of inspection. Outdoor spaces, indoor communal spaces and corridors were also decorated with crafts and artworks which had been created by residents which added to an inclusive, homely environment.

Staff provided appropriate support to residents to allow them to enjoy their meals. Residents were observed to be offered a choice at meal times, including residents who required modified diets. Menus were displayed in the dining rooms to inform residents about the options available. Menus were also available in pictorial form for residents who may have difficulty interpreting a written menu or in communicating their preference. The photographs of the foods for the pictorial menus were taken of the actual food served in the centre rather than using generic images. This was to ensure residents were appropriately informed of the meal they could expect to receive. Some residents required assistance from staff with their meals, and where this was the case, staff were observed treating residents with respect and dignity and were seated next to residents throughout their meal. Residents were observed to take their meals in a place of their own choosing, with some eating in communal dining rooms and others eating in their bedrooms. This choice was respected by staff, and appropriate supervision was provided for all residents during the meal time. Meals provided were well presented and nutritious and residents had access to refreshments at all times. The inspectors also observed the meals provided to residents who required modified texture diets and found that although residents' care plans may not have been up to date as discussed under Regulation 21: Records, those residents still received meals aligned to their most recently assessed needs. There was a clear communication system in place to ensure staff were informed of residents' dietary needs and preferences, including when there were changes to the residents' needs.

The person in charge had ensured that residents' needs were comprehensively assessed on admission to the centre, and again at regular intervals and in response to changes in their condition. Staff showed a good knowledge of residents' assessed needs. The inspectors reviewed a sample of nine care plans, including absconsion and missing person care plans, communication care plans, nutrition and hydration

care plans, safeguarding care plans and cognitive function and behavioural pattern care plans. All care plans reviewed had been developed within 48 hours of the resident's admission to the centre and there was evidence that the residents and their family members were involved in the care planning process as appropriate. However, inspectors found that care plans were not always updated in response to changes in residents' assessed needs as discussed under Regulation 5: Individual assessment and care plan. Staff spoken with were knowledgeable of the current needs for residents, and told inspectors that gaps in the written records were due to a busy workload which was resulting in a lack of protected time for them to ensure records were kept up to date.

Some residents in the centre had specific communication needs, for example, due to language barriers, impaired hearing ability or vision impairment, whilst others had difficulties expressing themselves. Detailed communication care plans were in place for these residents, which clearly described the residents' communication needs and communication barriers, and provided detailed information for staff in how to effectively communicate with the resident.

Inspectors reviewed the risk management policy in place in the centre. The policy in place did not detail the actual measures and actions that were in place in the centre to control the risks which are specified in the regulations. This finding is discussed in more detail under Regulation 26: Risk management.

There were good medicine management systems in place in the centre. Current medicine prescriptions and discontinued medicines were individually signed by the medical officer. Controlled drugs were carefully managed in accordance with professional guidance.

Regulation 10: Communication difficulties

Residents who had specialist communication requirements had person-centred care plans in place, which clearly outlined their specific communication needs. Communication care plans were sufficiently detailed to guide staff in communicating effectively with those residents

Judgment: Compliant

Regulation 17: Premises

The premises was clean and suitably decorated. There was sufficient communal space for residents and the premises was found to meet all requirements of schedule 6 of the regulations.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had good access to food, drinks and snacks. Meals were served at reasonable times, and residents were offered a choice at meal time. There was sufficient number of staff available to assist and supervise residents at meal times. Residents with specific dietary needs were observed to receive meals aligned to their assessed needs.

Judgment: Compliant

Regulation 26: Risk management

Although the registered provider had in place a policy for managing risks in the centre, this policy did not clearly set out the specific measures and actions in place to control each of the risks set out under Regulation 26 (1)(c)(i) through to (vi).

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medicines were administered to residents in line with the centre's policy. There was an appropriate pharmacy service offered to residents and a safe system of medication administration in place. Policies were in place for the safe disposal of expired or no longer required medications.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The registered provider and person in charge had not ensured that individual assessment and care plans reflected the specific current assessed needs of residents. This is a repeat finding and was evidenced by the following examples;

- One resident who had been reviewed by the dietician, with changes identified to their dietary needs, did not have their records updated to include this information in their nutritional care plan.

- One resident who presented with behaviours that challenge had an assessment and cognitive function and behavioural pattern care plan in place, however, this resident's care plan did not detail the specific types of behaviours that this resident presented with and was written in a generic manner which did not effectively inform and guide staff in how to care for this resident.

Judgment: Not 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 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Not compliant

Compliance Plan for Anna Gaynor House OSV-0000465

Inspection ID: MON-0049967

Date of inspection: 25/03/2026

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

The process of staff supervision will be reviewed to ensure Clinical Nurse Managers (CNM) strengthen day to day supervision, staff support and performance oversight with their teams on all units in Anna Gaynor House.
Completion date: 26/06/2026

Based on the above learnings the Person in Charge (PIC) will provide enhanced operational oversight, supervision, and professional support to CNMs.
Completion date: 10/07/2026

CNMs on all units will be expected to improve supervision arrangements through increased visibility, structured staff support and consistent operational oversight to protect and promote the care and welfare of all residents. This arrangement will include appropriate supervision of staff carrying out all safe and effective care duties and a review of care plan governance processes to support effective person centred care planning.
Completion date: 31/07/2026

CNMs and Support Services Supervisors/Manager to communicate the expected storage standards in the unit and complete regular checks of all rooms to ensure that equipment, supplies and personal staff items are stored in the appropriate designated areas.
CNMs and Support Services Supervisors/Manager will deal with day to day matters relating to non-compliance of this standard with staff. If repeated patterns of non-compliance are observed appropriate escalation, supervision and performance management processes will be implemented.
Completion date: Ongoing monitoring

Review Clinical Nurse Manager rostering arrangements in the centre on all units to

ensure consistency of CNM 1 and 2 cover Monday to Friday (with the exception of annual leave and unexpected leave of absences).
Completion date: 26/06/2026

Understanding of the Health Act 2007 will be communicated to staff through a tool box talk which will include understanding of the regulations as they apply to the unit, supported by discussion with staff to allow opportunities for questions and clarifications. This will be applicable for all current staff and will be communicated with all new staff on commencement of employment in the centre. A centralised location will be identified in each ward to ensure the Health Act and related documents are easily accessible to staff.
Completion date: 31/07/2026

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Human Resource Department will complete a review of all staff files from the designated centre to ensure that they contain all Schedule 2 requirements including a full employment history inclusive of any gaps in employment. Once completed, this process will apply to new employees commencing work in the unit.
Completion date: 02/10/2026

CNMs on all units to ensure oversight arrangements are in place for appropriate storage of confidential records and documents. CNMs and Heads of Department (HOD) will communicate the expected storage standards in the unit and complete regular checks that standards are upheld. Reminder at weekly SAFE (Situational awareness for all) meetings and at ward staff meetings to ensure all members of the Multi-Disciplinary Team (MDT) are aware of their responsibility to maintain record confidentiality. The Patient Services team and the Information Governance & Compliance Lead will maintain a programme of independent audit of required storage standards. If repeated patterns of non-compliance are observed appropriate escalation, supervision and performance management processes will be implemented by CNMs and HODs.
Completion date: Ongoing monitoring

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The dependency levels across all wards are monitored and risk assessed on a weekly basis at the Multidisciplinary Team (which includes the PIC &/or deputy, Consultant Geriatrician for the centre, CNM/SN from each ward, and Health and Social Care Professionals in attendance) SAFE (Situation awareness for all) meeting. Review nursing and healthcare assistant allocation and rostering practices in the centre on all units taking into consideration resident dependency, acuity and ward occupancy to support staffing allocations.
Completion: Ongoing

CNMs on all units will review care plan governance processes to support effective person centred care planning to ensure resident's care plans evidence any change in their condition in a timely manner. CNMs on all units will ensure staff are afforded time to update documentation to ensure all residents have cohesive, consistent, and effective plans of care in place. CNMs on all units will maintain a programme of Test Your Care auditing and action plan response to oversee and monitor the required care plan standards.
Completion date: 30/10/2026

CNMs on all units to ensure oversight arrangements are in place for appropriate storage of confidential records and documents. CNMs and Heads of Department (HOD) will communicate the expected storage standards in the unit and complete regular checks that standards are upheld. Reminder at weekly SAFE (Situational awareness for all) meetings and at ward staff meetings to ensure all members of the Multi-Disciplinary Team (MDT) are aware of their responsibility to maintain record confidentiality. The Patient Services team and the Information Governance & Compliance Lead will maintain a programme of independent audit of required storage standards. If repeated patterns of non-compliance are observed appropriate escalation, supervision and performance management processes will be implemented by CNMs and HODs.
Completion date: Ongoing monitoring

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
PIC and Quality & Patient Safety Lead to review and outline the specific measures and actions in place to control each of the risks set out under Regulation 26 in the Enterprise Risk Management policy.
Completion date: 31/07/2026

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:
CNMs on all units will be expected to improve supervision arrangements through increased visibility, structured staff support and consistent operational oversight to protect and promote the care and welfare of all residents. This arrangement will include appropriate supervision of staff carrying out all safe and effective care duties and a review of care plan governance processes to support effective person centred care planning.
Completion date: 30/10/2026

CNMs on all units will review care plan governance processes to support effective person centred care planning to ensure resident's care plans evidence any change in their condition in a timely manner. CNMs on all units will ensure staff are afforded time to update documentation to ensure all residents have cohesive, consistent, and effective plans of care in place. CNMs on all units will maintain a programme of Test Your Care auditing and action plan response to oversee and monitor the required care plan standards.
Completion date: 30/10/2026

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.	Not Compliant	Orange	31/07/2026
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Not Compliant	Orange	31/07/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	02/10/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	22/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/10/2026

	designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/10/2026
Regulation 26(1)(c)(vi)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control infectious diseases.	Substantially Compliant	Yellow	31/07/2026
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	31/07/2026
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the	Substantially Compliant	Yellow	31/07/2026

	measures and actions in place to control the unexplained absence of any resident.			
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	31/07/2026
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Substantially Compliant	Yellow	31/07/2026
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Substantially Compliant	Yellow	31/07/2026
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	Not Compliant	Orange	30/10/2026

	accordance with paragraph (2).			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	30/10/2026