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:	Ferbane Care Centre
Name of provider:	Maracrest Ltd.
Address of centre:	Main Street, Ferbane, Offaly
Type of inspection:	Unannounced
Date of inspection:	12 August 2025
Centre ID:	OSV-0004690
Fieldwork ID:	MON-0042831

About the designated centre

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

Ferbane Care Centre is a 61-bedded facility set in mature grounds. It is a four-storey building and a lift and stairs provide access to each floor. It consists of 51 single rooms and five twin rooms, some of which are en suite. Residents' communal accommodation includes a day room and dining area on each floor, as well as a chapel and a drawing room. There are a number of toilets and bathrooms throughout the building. Kitchen and laundry facilities are located on the lower ground floor. There are nurses and care assistants on duty covering day and night shifts. The centre's statement of purpose outlines that the ethos of care is to promote the dignity, individuality and independence of all residents. The centre provides general nursing care predominately for older people but also for residents over 18 years of age. People who require short term and long term care are also accommodated in the centre.

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
Tuesday 12 August 2025	19:45hrs to 22:45hrs	Laurena Guinan	Lead
Wednesday 13 August 2025	10:35hrs to 17:05hrs	Laurena Guinan	Lead
Tuesday 12 August 2025	19:45hrs to 22:45hrs	Sarah Armstrong	Support
Wednesday 13 August 2025	10:35hrs to 17:05hrs	Sarah Armstrong	Support

What residents told us and what inspectors observed

Residents told inspectors that Ferbane Care Centre was a lovely place to live, with staff described as being kind and attentive. The inspection took place over two days, which included night time hours on the first day.The general atmosphere on both days was calm and relaxed. Call bells were answered promptly, and residents told inspectors that staff were quick to respond to their needs.

On arrival, inspectors observed the handover from the day staff to night staff, then went for a walk around the centre. The centre is spread out over four floors, with resident accommodation on all but the second floor. The lower ground floor has a hairdresser's salon, occupational therapy room, laundry, stores and staff facilities. The occupational therapy room was seen to be storing a substantial amount of surplus equipment such as walking frames, mattresses and armchairs, which rendered it unsuitable for residents' use. A store room had also been converted into a laundry room without notification to the Chief Inspector of Social Services. This will be discussed under Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration.

There is a separate unit on this floor called the Armstrong Wing which accommodates five residents. The unit comprises of a sitting room, dining room, store room, and five en-suite bedrooms. The communal areas were seen to have worn and broken furniture, damaged flooring and a layout that was not conducive to a homely environment. There was access to a secure courtyard through two doors with keypads. The courtyard had gravel pathways, making it unsuitable for those with mobility issues, and was lined on one side by old buildings in a state of disrepair that were being used for storage.

The ground and first floors each had dining areas, communal rooms, and a mix of single and twin bedrooms. Most bedrooms were en-suite, while others shared bathrooms. A shared bathroom on the ground floor was locked, and staff said this had been out of use for over a year. It was due to be refurbished, but staff did not know when this was to happen. On the first day of inspection, inspectors saw items such as slings and pressure relieving cushions on chairs and window-sills in communal rooms, bedrooms and store-rooms, which did not support good infection control. Inspectors were told the items were no longer in use. This was brought to the attention of staff, and some of the items were removed on the second day of inspection. Inspectors looked at the layout of the twin bedrooms, and were not assured that they afforded sufficient privacy to each occupant. This will be discussed later in the report.

On the second day of inspection, inspectors observed lunch being served. While residents were complimentary of the choice and quantity of food available, the dining experience overall was not a relaxed, person-centred affair. Most residents were seen to be wearing clothing protectors, and inspectors did not see that residents had requested or consented to this. Many of these residents were able to

have their meals independently. On all three residential floors, residents were seen having their meal in the sitting rooms, being assisted by staff or using low bed tables. Staff confirmed that some residents preferred this, but that it was also due to a lack of space in the dining rooms. This meant that some residents were in the same room from morning until bedtime.

Inspectors saw many kind and respectful interactions over both days, and both residents and staff commented on the staff's attention to detail when caring for residents. One resident said 'there is no pressure here', and inspectors saw that residents were given a choice of when to go to bed, with some preferring to stay up late in the sitting room, or watch late night TV in their bedrooms. On encountering a resident walking with a staff member through the corridor, the resident introduced the staff member to the inspector saying "this is my friend". Staff and residents appeared to know and understand each other well.

Inspectors saw residents on the first floor engaging in chair exercises on the morning of the second day, and in the afternoon many residents enjoyed the good weather outside, with drinks and ice-cream. The residents who remained inside, while they were supervised, were not engaged in any meaningful activities. Residents had access to the outdoors through the secure courtyard on the lower ground floor, and the garden area at the front of the centre. One resident said 'we get brought out for walks around the grounds – it's lovely to get outside', while another resident told inspectors 'you can't go outside on your own, it's one of the rules here'. The doors to the outdoor areas are accessed by keypads. The keypad code is displayed on a butterfly symbol for those residents who have been assessed as independently mobile and safe to access outdoor areas without staff assistance. Residents who are not independently mobile or have poor safety awareness rely on staff to accompany them outside, which restricts their opportunities to spend time outdoors. This does not support a rights-based approach to care and will be discussed later in the report.

Inspectors spoke with a number of visitors on both days, and they all felt their loved one was safe and well cared for. Visitors were made to feel welcome at any time, and staff were responsive to any concerns raised. Those whose relatives were receiving end-of-life care said they were treated very well, and that families could stay overnight or visit as and when they wanted.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found that the registered provider had ensured a good standard of care and support for those living in the centre. There were suitable arrangements

in place to ensure that the centre was adequately resourced to meet the assessed needs of residents living in Ferbane Care Centre, in accordance with the centre's statement of purpose. However, the registered provider had changed the functions of some rooms within the designated centre without informing the Chief Inspector of those intended changes. As a result, the registered provider was in breach of Condition 1 of their registration. Additionally, inspectors found that the oversight systems in place were not sufficiently robust to ensure that the service provided was safe and effectively monitored. This is discussed further under Regulation 23: Governance and management.

This was an unannounced inspection carried out over one evening and the following day to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the compliance plan from the previous inspection, and statutory notifications submitted to the Chief Inspector since the last inspection in September 2024. Inspectors found that the registered provider had failed to fully implement the compliance plan from the inspection in September 2024 in respect of communication with staff, and this is discussed under Regulation 23: Governance and management.

The registered provider of Ferbane Care Centre is Maracrest Limited, which is part of Windmill Nursing Home Group Limited. There was a clearly defined management structure in place with responsibility for the delivery and monitoring of care to the residents. There was a person in charge who worked full-time in the centre and who was supported in their role by two assistant directors of nursing and a team of clinical nurse managers. Staff nurses, healthcare assistants, activities coordinators, household, catering and maintenance staff made up the remainder of the staff team in the centre.

There was an ongoing schedule of training established to ensure that staff had access to appropriate and up-to-date training to support them in performing their duties. From a review of staff records, inspectors found that the provider had maintained an induction and appraisal system for staff to support them to develop in their roles. Inspectors also spoke with a number of staff on both days of inspection who told inspectors that they felt supported in their roles.

Records set out in Schedules 2, 3 and 4 were maintained in the designated centre and were available for review by inspectors. Whilst there were processes in place to ensure the retention period of records, inspectors found that the management of records within the centre required further oversight to ensure residents' records were kept in a manner which was safe and secure. This is discussed further under Regulation 21: Records.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider had failed to notify the Chief Inspector of changes to the

footprint of the centre, and to the change in use of rooms:

- An area in the Gallen Wing had been reconfigured to create a store room, and the location of the door to the stairwell had subsequently been changed.
- On the lower ground floor, a store-room had been reconfigured to accommodate a laundry.
- On the lower ground floor, an occupational therapy room was being used to store equipment.

Judgment: Not compliant

Regulation 15: Staffing

There were sufficient numbers of staff available with the required skill mix to ensure that residents' needs were met in a prompt manner.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their roles. Inspectors reviewed the training matrix in the centre and found that there were high levels of compliance with mandatory training including safeguarding, manual handling and fire safety training. A review of staff files provided evidence that staff appraisals were being completed to support staff to develop in their roles. Staff spoken with told the inspectors that they felt supported in their roles.

Notwithstanding some positive findings under this regulation, the inspectors observed that staff were not appropriately supervised and the oversight of staff practices in the centre was insufficient. For example:

- During the meal time experience, inspectors observed the majority of residents wearing clothing protectors, despite the fact that many were able to eat independently and management confirmed they did not require these. In addition, inspectors observed one staff member standing over a resident to assist them with their meal which was impacting on the resident's right to dine with dignity. Staff were also observed to be multi-tasking when assisting residents with their meals resulting in an inconsistent meal-time experience, and a lack of a person centred approach for residents.
- A number of fire doors with signage advising doors to be kept closed were observed to be open on both days of inspection.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors reviewed a sample of four staff files and found that these records met all requirements of Schedule 2 of the regulations. All staff had valid Garda vetting in place.

However, inspectors found evidence that not all records were kept in such a manner as to be safe. For example:

- Residents' nutritional records were observed to be kept on notice boards within the dining rooms which was accessible to all residents, staff and visitors within this communal space.
- Inspectors observed a folder containing information about residents' needs, including their individual continence needs and food and fluid charts, which was unattended and unsecured in a resident's communal space.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- There was insufficient oversight from management to ensure that the Chief Inspector was informed of changes to the footprint of the centre.
- The oversight systems in place did not ensure that the compliance plan from the previous inspection was implemented. The ineffective communication from management on matters impacting on residents and staff was a repeat finding on this inspection. For example:
    - Residents were not updated on the exact date that fire works were scheduled to commence in the centre.
    - Staff told the inspectors that a bathroom on the ground floor had not been functioning for over a year, however the staff were unaware of the plans to upgrade this room or when the upgrades were due to commence.
    - One resident receiving end-of-life care had been relocated to another room in the centre. While family members had been informed of the move, they told inspectors that they did not know the reason for it.

Inspectors reviewed a sample of audits, including environmental, fire safety and falls audits. However, further oversight was required to ensure that where improvements

were identified, these were implemented appropriately by staff. For example:

- An environmental audit completed on 11 July 2025 failed to identify issues found during the inspection in respect of the damaged and worn furniture, and the overall appearance and cleanliness of the centre. These findings are set out under Regulation 17: Premises.
- A fire safety audit completed in July 2025 had not identified failures in the integrity and functionality of fire doors identified by inspectors on this inspection.
- An audit of residents' falls was completed on 28 July 2025 and identified delays or gaps in staff carrying out routine checks on residents. Inspectors observed resident records on the day of inspection and found that one resident's routine checks were completed by staff ahead of time.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The centre's policies and procedures were up to date and available for review by the inspectors. Policies and procedures required under Schedule 5 of the regulations were reviewed, and had been updated within the required time frame of three years.

Judgment: Compliant

Quality and safety

Overall, residents in Ferbane Care Centre were seen to receive a high standard of care from staff who were familiar with their needs. However, the inspectors observed issues with the premises and institutional practices which impacted on the residents' choice and quality of life.

Inspectors looked at a sample of care plans with a focus on pre-admission assessment, communication difficulties, and end-of-life care. Care plans were seen to be developed within 48 hours of admission, and used validated assessment tools. Daily records showed that care was carried out as detailed in the care plans, and staff spoken with were knowledgeable of residents' care needs. Pre-admission assessments were seen to be comprehensive and identified residents' needs accurately. For example, a resident who was identified as having significant behavioural issues prior to admission was allocated a room that allowed for enhanced supervision.

Residents who had communication difficulties had detailed information in their care

plan to direct staff in how to communicate with them. For example, a resident who was non-verbal had information specific to them about their non-verbal cues and gestures.

The centre had an end-of-life policy in place, and each resident had an end-of-life care plan. These were seen to be completed in consultation with residents and families. The care plans were personalised with details such as type of funeral ceremony and resting place preferred. Inspectors spoke with family members of those on active end-of-life care. They reported that they were accommodated to be present as much as they wanted, and there was excellent communication from staff about their loved one's condition. Those residents were also engaged with a palliative care team, whose recommendations were documented and followed by staff in the centre.

The person in charge had engaged the services of an external laundry provider, and there were also laundry facilities and laundry staff onsite. Residents and visitors were happy with how clothes were cared for, and had not experienced clothes or belongings going missing. Each bedroom was seen to have a locker and wardrobe for each resident, although one twin bedroom, which was vacant on the day of inspection, had only one wardrobe.

The centre had a spacious, attractively furnished oratory which staff told inspectors was used regularly, however, there was no call bell in the room should a resident need to call for assistance. Inspectors also observed that a number of call bells in communal rooms had a call bell installed, but the cord was missing or broken, which could make it difficult for residents to use. This will be discussed under Regulation 9: Residents' rights.

The outdoor areas that residents could access had gravel pathways unsuitable for those with mobility issues. The outdoor area to the front of the building was unsecured and accessed by crossing a gravel driveway. This meant that residents wishing to spend time outdoors had to do so in the company of staff, either for physical assistance to navigate the pathways, or to negate the risk of harm due to passing vehicles or absconsion. This did not support a rights-based approach to care. The main smoking area was located at the front entrance, meaning residents and visitors passed through the smoking area when coming to and going from the centre, and at times a strong smell of smoke was noted in the reception area and the living room adjacent to it. On the second day of inspection, there was a lot of activity outside, with residents, staff and visitors accessing the front garden, and ambulances transferring residents to and from hospital. At times, people were standing in the smoking area waiting for others to pass. This meant that residents had people encroaching on their space while they were enjoying their cigarette.

Throughout the centre, inspectors saw a lack of attention to detail with regards to cleanliness and maintenance of the premises, and they were not assured that the premises were designed and laid out to meet the needs of residents. Externally, the windows were visibly dirty, and this was noticeable from residents' bedroom windows, where their view was spoiled by heavy grime and bird droppings. Internally, inspectors saw fire doors that had not been repaired properly, resulting in

open holes. Other fire doors did not close fully, and the emergency lighting over the main entrance was broken. Many areas had paintwork that was chipped, and worn and or broken furniture, and some areas of flooring were seen to be damaged. This did not facilitate proper cleaning, as well as being aesthetically unpleasant. The damaged flooring also posed a risk to residents as they moved around the centre. While residents had wardrobe and locker space in their bedroom, many rooms did not have a lockable storage space. A number of those with lockable storage did not have a key available.

Inspectors observed the layout of the twin bedrooms and the communal rooms on each floor. Some of the twin rooms did not allow privacy screening to be used in a way that allowed both residents to access the bathroom and their wardrobe, or view their TV. This was discussed with the person in charge who stated that the rooms were generally used as single occupancy, but were kept as twin rooms to facilitate spouses or siblings who wished to share a room. The layout of the communal rooms were also discussed with the person in charge. The sitting rooms on each floor had chairs and couches placed around the perimeter of the room. This meant that some residents were sitting directly facing each other across a room, or in the case of the Armstrong Wing, facing a wall. This layout did not promote a homely environment, or encourage residents to engage with each other in small groups. This reinforced an institutional set up where the dignity and privacy of residents was compromised, as it meant that when one resident was being assisted by staff or receiving visitors, others could easily watch. These issues will be discussed under Regulation 17: Premises.

Residents and visitors were very complimentary of the food available, and the meals looked to be fresh and nutritious. Inspectors were told that catering staff paid great attention to individual preferences, which was important to the residents. Residents were given a choice of meals, and special requests were accommodated. All staff were aware of residents requiring a modified diet, and there was adequate staff to assist residents at meal-times. However, not all residents were afforded the same dining experience and those being assisted with meals in the sitting room were not always attended to in an appropriate manner. For example, some residents were assisted by staff who were simultaneously attending to other tasks, which did not promote residents' dignity. A resident on a modified diet was observed to be on a bean bag on the floor while having their meal. This posed a risk of choking, as the resident was not in an upright position. The dining experience will be discussed under Regulation 18: Food and nutrition.

Regulation 10: Communication difficulties

Residents were facilitated to communicate freely, and care plans detailed specialist communication requirements.

Judgment: Compliant

Regulation 12: Personal possessions

Residents' clothes were laundered regularly and returned to them. Residents had adequate space for their clothes and personal possessions.

Judgment: Compliant

Regulation 13: End of life

Residents had end-of-life care plans which detailed their wishes. Those receiving end-of-life care were seen to be afforded appropriate care and comfort. The residents' families were facilitated to be present with them.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured that the premises conformed to the matters set out in Schedule 6, including:

- Communal spaces were laid out in a way that was not homely, and did not promote or encourage social interaction.
- Damaged doors, walls, and floor coverings.
- Chipped and flaking paint work throughout the centre.
- Heavy dirt was visible on windows.
- Maintenance issues such as loose electrical sockets, missing call bells, and call bells with broken or frayed cords.
- Some areas were visibly dirty such as store-rooms and windowsills.
- Bedrooms and communal rooms had furniture that was broken, dirty and or worn.
- The sitting room on the Armstrong Wing was not suitably decorated to facilitate relaxation, and a homely environment.
- Twin bedrooms required reconfiguration and review to ensure they are suitable for twin occupancy.
- Lack of lockable storage space in residents' bedrooms.
- Inappropriate storage of residents' equipment, such as bed-frames stored in communal spaces.

Judgment: Not compliant

Regulation 18: Food and nutrition

The person in charge had not ensured that there was an adequate allocation of staff to assist at meal times, resulting in:

- Residents being assisted by staff who were simultaneously undertaking other tasks.
- Residents not being assisted to sit in an appropriate position or space in which to have their meal.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents had a comprehensive pre-admission assessment completed. Validated assessment tools were used to develop care plans within 48hrs of admission and these were reviewed every four months or as required.

Judgment: Compliant

Regulation 9: Residents' rights

While the registered provider had provided access to outdoor spaces, the design of the spaces meant that residents did not have the choice to access them independently, freely, or in private.

The registered provider had failed to ensure that all residents could exercise choice which did not interfere with the rights of other residents. This was evidenced by:

- Not all residents were afforded the same dining experience. Some residents were required to eat their meals in the communal space and one resident was seen to be assisted with their meal on a bean bag.
- The location of the smoking area at the front of the building interfered with the rights of all residents. For example, residents who chose to smoke could not do so privately and those who chose not to smoke were impacted by the smoke due to the location of the smoking area.

The registered provider had not ensured that all residents had the facilities to undertake personal activities in private, for example, residents in the twin rooms did not have sufficient space to access their wardrobe or watch TV in private. Not all residents were afforded opportunities to participate in activities in accordance with

their interests and capacities. Some residents were observed to be supervised by staff in the communal areas with no meaningful engagement or activities being provided.

While residents had been informed that fire works were scheduled to take place in the centre, they were not given notice of the exact dates of commencement. Residents told inspectors that they were surprised when building works commenced at 8am one morning.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ferbane Care Centre OSV-0004690

Inspection ID: MON-0042831

Date of inspection: 13/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration: The Chief Inspector was notified of the variations to the footprint and room usage within the centre, including the reconfiguration of rooms in the Gallen Wing and lower ground floor (notification submitted on 16/10/2025) (completed). • The Statement of Purpose has been updated to reflect the reconfigured use of space, including changes to the stairwell door, the conversion of a storeroom into a laundry, and the use of the occupational therapy room (updated 16/10/2025) (completed).	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A Dining/Mealtime Experience Audit was completed by the Clinical Nurse Manager on 06/10/2025 and will now be carried out monthly to evaluate person-centred mealtime practices and ensure continuous improvement (next audit by 06/11/2025). • The designated dining assistant staff member will support the care team during mealtimes and ensure a positive, respectful dining experience for residents. (ongoing). • Re-education sessions for all care staff on person-centred dining, appropriate use of protective clothing, and maintaining resident dignity were completed on 06/10/2025, led by the Person in Charge. These sessions will be repeated as part of staff induction and	

monitored during routine audits (next refresher by 31/01/2026).
• The importance of obtaining verbal consent from residents prior to the use of clothing protectors has been reinforced through supervision and will be monitored as part of the monthly dining experience audit (ongoing).
• A fire door audit has been completed, and additional clear signage instructing that doors must be kept closed has been installed (completed).
• Daily management walkabouts are ongoing to monitor compliance and provide staff with ongoing re-education and reminders on adhering to fire safety precautions (ongoing).

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Following the inspection, all clinical and care records — including nutritional information, food/fluid charts, and continence details — were removed from communal areas and are now securely stored within the nurses' station (completed).
• A centre-wide re-education programme was initiated following the inspection to reinforce staff understanding of the GDPR policy and confidentiality protocols. This includes appropriate handling, storage, and disposal of sensitive resident information (ongoing).
• All staff are required to read and sign an acknowledgment of the centre's GDPR and confidentiality policy by 31/10/2025, as part of mandatory compliance documentation (by 31/10/2025).
• The Person in Charge and ADON will monitor and audit staff compliance monthly, including spot checks on documentation storage practices across all units to ensure ongoing adherence to privacy standards (first audit by 15/11/2025, then monthly thereafter).

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A weekly operational meeting involving the company engineer, Person in Charge, and relevant management representatives has been implemented to oversee the construction works and ensure timely updates and actions (ongoing).
• Daily communication on building works and maintenance is shared during staff handovers, ensuring all team members are briefed on current and upcoming work (ongoing).

• Residents are updated weekly on construction progress through informal discussions and resident meetings, and families are provided with monthly updates via the Altra communication app (ongoing).
• Information signage has been placed in the centre's main entrance to inform visitors and families of ongoing works and expected timelines (completed).
• Oversight of the centre's compliance plans has been strengthened, with weekly reviews conducted by senior management to monitor implementation status and address outstanding actions in a timely manner (ongoing).
• Audit processes have been revised to ensure meaningful evaluation of environmental conditions, fire safety, and falls prevention. All relevant audit tools were reviewed and updated by the Quality and Safety Manager to improve the identification of risks (next audit by 31/10/2025).
• The senior management team reviews and approves all proposed structural or functional changes within the centre. Any such changes are communicated to the Chief Inspector prior to commencement (ongoing).

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A full environmental audit was completed by the PIC, Maintenance Manager and Company Engineer on 10/10/2025 to identify all required works across the premises. A structured schedule of remedial actions is now in place with defined completion dates and oversight by the weekly management and engineering meetings (ongoing).
• Damaged and worn structural elements (doors, walls, floors, chipped paintwork) are being repaired and repainted to improve the appearance, hygiene, and homeliness of the environment. Painting and flooring works commenced and are scheduled in phases with full completion by 31/01/2026.
• Cleaning of previously unclean areas, including windows, store rooms, and windowsills, was initiated immediately following inspection. A deep clean was completed on 06/10/2025, and enhanced environmental checks are now in place and monitored by the housekeeping supervisor (weekly checks ongoing).
• Missing or damaged call bells were replaced or repaired, and a new call bell was installed in the oratory to ensure all rooms are appropriately equipped (completed).
• Maintenance of communal spaces, including layout and furniture replacement, is ongoing to improve comfort and social engagement. Repairs to damaged furniture are underway, and unsuitable items are being replaced. This work will be completed by 31/12/2025.
• The sitting room on Armstrong Wing is being redecorated to improve its suitability as a calm, homely environment for residents (Completed).
• Tarmacking of the gravel path in the rear courtyard has been included in the environmental improvement plan (by 31/03/2026).
• Reconfiguration of shared bedrooms is being reviewed to improve privacy, access to personal space, and overall layout. This review includes ensuring that all residents have sufficient access to their wardrobes and televisions (review to be completed

15/11/2025).
• Lockable storage is being installed in bedrooms currently without secure storage solutions to support residents' privacy and autonomy (by 31/12/2025).
• Improper storage of equipment in communal areas has been addressed. Unused equipment has been relocated and a new storage protocol introduced to ensure compliance with fire and infection control standards (monitored weekly).
• Window cleaning will be completed by 31/10/2025 and will be incorporated into a planned cleaning schedule to take place twice yearly, ensuring high standards of environmental hygiene are maintained.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The Dining Assistant, already appointed, will support staff during mealtimes, ensuring residents receive timely and focused assistance without multitasking (completed).
• The resident who had been seated on a bean bag was reassessed by nursing and physiotherapy staff and now sits in a suitable supportive chair for meals (completed).

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A full review of residents' access to outdoor areas was completed. The Butterfly Code is in place for residents assessed as able to access outdoor spaces independently, enabling safe, unassisted access while maintaining appropriate oversight (completed).
• Risk assessments are completed for residents wishing to access external areas, and access is supported in line with their preferences and abilities (ongoing).
• Residents continue to be consulted through monthly forum meetings. Planned works, including timelines, are clearly communicated in advance, with written notices and verbal updates provided at least 48 hours prior to commencement (ongoing).
• A designated dining assistant is in place to support a positive, inclusive mealtime experience. Residents are now appropriately seated, including reassessment for any resident requiring alternative seating (completed).
• Staff have been reminded to offer all residents the choice of dining location, and residents no longer eat exclusively in one communal space unless by personal preference or assessed need (ongoing).
• Staff will complete a training session on delivering care using a human rights-based approach, ensuring respect for residents' autonomy, dignity, and equality of experience (by 15/11/2025).

• The activities schedule has been reviewed and revised to ensure meaningful engagement is provided to all residents throughout the day. One-to-one and small group sessions have been reintroduced for residents with higher support needs (implemented 10/10/2025, ongoing).
• Twin rooms have been reorganized to improve personal space, including TV positioning and access to wardrobes. Room layout audits are being completed for all shared rooms (completed).
• An alternative temporary smoking area has been identified to support resident privacy and minimize exposure to smoke for non-smoking residents, while plans are underway to develop a more structured and permanent solution (by 31/01/2026).

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
Registration Regulation 7 (1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition or conditions of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	18/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2026
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that	Substantially Compliant	Yellow	15/11/2025

	centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	31/03/2026
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	16/10/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	15/11/2025
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	31/10/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and	Substantially Compliant	Yellow	16/10/2025

	recreation.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	16/10/2025
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	31/01/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	16/10/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	16/10/2025