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:	Cratloe Nursing Home
Name of provider:	Cosgrave Nursing Consultancy Limited
Address of centre:	Gallows Hill, Cratloe, Clare
Type of inspection:	Unannounced
Date of inspection:	29 April 2026
Centre ID:	OSV-0005393
Fieldwork ID:	MON-0050407

About the designated centre

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

Cratloe nursing home was originally built as a domestic dwelling which had been extended and adapted over the years to meet the needs of residents. It is located in a rural area on the outskirts of the village of Cratloe in Co. Clare. It is split level building and it accommodates up to 32 residents. Accommodation for residents is provided on both levels with a lift provided between floors. It provides 24-hour nursing care to both male and female over the age of 18 years. Care is provided for people with a range of needs: low, medium, high and maximum dependency. It provides short and long-term care primarily to older persons. There are nurses and care assistants on duty covering day and night shifts. Accommodation is provided in both single and shared bedrooms. There are separate dining, day and visitors rooms as well as an enclosed garden courtyard area available for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	29

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 29 April 2026	09:35hrs to 18:15hrs	Rachel Seoighthe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection which was carried out over one day. With the exception of feedback in relation to the choice of activities, residents, and visitors, were complimentary of the service provided. Staff were observed to be helpful and kind towards residents, and the inspector heard positive comments the kindness of staff, who were described as 'brilliant'.

The inspector was greeted by the person in charge upon arrival to the centre. Following an introductory meeting, the inspector spent time walking through the centre, giving an opportunity meet with residents and staff.

Located in the village of Cratloe, Co. Clare, Cratloe Nursing Home is registered to provide care for a maximum of 32 residents. The centre was a purpose built split-level facility. Access between floors was by stairs or passenger lift. On the day of inspection, there were 29 residents living in the centre

The entrance to the centre opened into a reception, offices, a visitors room and utility rooms. Resident private accommodation areas were also located on the ground floor, which accommodated up to 13 residents. Communal rooms, clinical rooms and resident bedrooms were located on the first floor of the centre. An enclosed courtyard garden was accessible from this area of the centre.

As they walked through the centre, the inspector observed that many residents were up and about in the communal areas. The atmosphere in the centre was relaxed. Some residents were receiving visitors in their bedrooms. A small number of residents were observed resting in their bedrooms, and several residents were seen spending time in the enclosed courtyard garden, which was also the location for the designated smoking area. There were measures in place to ensure residents' safety when using this facility, including access to suitable fire-fighting equipment.

Resident bedroom accommodation in the centre was comprised of 14 single and nine twin bedrooms. One single bedroom and one twin bedroom had en-suite facilities. All other bedrooms had shared toilets and showers, some were interconnected between two bedrooms and others were located on the corridors. Following a previous inspection a restrictive condition was attached to the centres registration, to reconfigure, or reduce the occupancy of bedroom 12 to ensure that any resident residing in the room is afforded 7.4m2 floor space, to include their bed, a chair and personal storage space by the 31 December 2023. The inspector observed that the provider had completed work to increase the bedroom floor space to 14.8m2. However, the inspector noted that, due to the layout of bedroom 12 and bedroom 13, they were better suited to accommodate residents who had low to medium dependency needs and who did not require the use of large items of mobility equipment.

The inspector observed that resident bedrooms were generally clean and tidy, and residents were encouraged to personalise their bedrooms with items of significance, including photographs and soft furnishings. Call bells and television were provided in each resident bedroom.

The majority of residents were seen spending time in the communal sitting room on the first floor, and the inspector noted that nursing and care staff were present constantly, to offer support and assistance to residents. There was a dining room nearby, which was used by residents throughout the inspection. Residents were complimentary of the quality of food provided, and the choice of menu offered. In conversation with a resident, they described being able to get a ''cappuccino'', at any time of day.

The inspector observed that some residents moved around the centre freely, throughout the day. Residents who chose to smoke were observed to spend time in the courtyard garden. Residents' told the inspector that they looked forward to an improvement in the weather, so that they could resume planting flower baskets in the courtyard. Several residents enjoyed reading and one resident informed the inspector of a recent delivery of new books to the centre, which they looked forward to organising in the library, with the help of the facilities manager.

There was a schedule of activities in place which included bingo, music and exercises. There were two members of staff dedicated to the provision of activities. However, on the day of inspection, the inspector was informed that one staff member was on planned leave, and the other staff member had been redeployed to another department, to cover unplanned leave. A music therapy activity was facilitated by an external provider in the communal sitting room, and while some residents took part, the inspector noted that several residents didn't engage in this activity. A small number of residents told the inspector that they weren't interested in some of the daily activities provided.

It was evident that the person in charge was well known to the residents and the inspector observed pleasant interactions with residents throughout the inspection. One resident described the support they had received since their arrival to the centre, while another resident praised the individual members of the management team. The inspector observed staff engaged in friendly conversation with residents.

The inspector observed visitors being welcomed to the centre and they spoke with two relatives who were visiting on the day of inspection. Both were very complimentary in their feedback and expressed satisfaction about the standard of care provided, and the responsiveness of staff and management. There was sufficient space for residents to meet with visitors in private. The inspector was informed that there were flexible visiting arrangements in place.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended). The inspector followed up on the provider's compliance plan response to the previous inspection in July 2025 in relation to residents rights, premises, fire precautions, the complaints procedure, and governance and management. Overall, this inspection found evidence of sustained improvements in many aspects of the service and the management team demonstrated a commitment towards achieving compliance. However, assessment and care planning, residents rights, premises, fire precautions and medicines management were not fully aligned with the requirements of the regulations.

Cosgrave Nursing Consultancy Ltd was the registered provider for Cratloe Nursing Home. The person in charge was a director of the company. They were supported in their role by a director of nursing and a clinical nurse manager. At the time of the inspection, the clinical nurse manager was on period of planned leave, and there was a vacancy for a receptionist. A governance officer, who worked part-time in the centre, was appointed to provide clinical oversight and support to the management team. Additional management support was provided by a facilities manager. A team of nurses, health care assistants, household, activity, catering, administration and maintenance staff made up the staffing compliment. There were deputising arrangements in place in the absence of the person in charge. The clinical management team were knowledgeable regarding the individual care needs of residents.

On the day of inspection, the number and skill mix of nursing and healthcare staff was appropriate, with regard to the needs of the residents being accommodated in the designated centre. However, staffing levels available for the provision of activities for residents were not adequate, due to unplanned leave. While the inspector was informed that health care assistants were allocated to facilitate activities in the absence of the activities coordinator, they noted that a limited number of activities took place on the day of inspection.

There was a training programme in place for staff, which included mandatory training and other areas to support the provision of care. Training records confirmed that staff were facilitated to attend training in fire safety, manual handling procedures and safeguarding residents from abuse.

There were management systems in place to oversee the service and the quality of care, which included a programme of auditing in clinical care and environmental safety. There was evidence of regular meetings with the various staff departments to review key aspects of the service. Agenda items included staffing, communication, documentation and key topics such as safeguarding and infection control. The clinical management team maintained a record of performance

indicators (KPIs) were reviewed in areas including falls, wounds and nutrition. Audits, which identified areas for quality improvement, had an associated action plan. However, the inspector found that monitoring of some aspects of the service, such as fire precautions was not effective, and did not ensure the safety and well-being of the residents. The internal system to identify deficits in the condition of fire doors was not being implemented, and issues found on inspection had not been identified or addressed by the provider.

An electronic record of all accidents and incidents involving residents that occurred in the centre was maintained. Records showed that notifications required to be submitted to the Chief Inspector were done in accordance with regulatory requirements.

There was a complaints policy in place, and this was updated in line with regulatory requirements. Records of complaints were maintained in the centre, and the inspector observed that these were acknowledged and investigated promptly.

A sample of staff personnel files were reviewed by the inspector. These were maintained in line with Schedule 2 of the regulations for the sector. Records of registration with the Nursing and Midwiferey Board of Ireland (NMBI) were available for nursing staff. There was evidence that each staff member had a garda vetting disclosure in place, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 and 2016, prior to commencing employment.

An annual review of the quality and safety of services delivered to residents in 2025 was completed.

Regulation 15: Staffing

Staffing resources allocated to the provision of social care on the day of inspection were not sufficient and did not ensure that all residents accommodated in the designated centre had access to meaningful occupation and entertainment in line with their preferences and capacity to participate, as described in the first section of this report.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safeguarding, managing behaviours that are challenging, as well as infection prevention and control. There was an ongoing schedule of training in place

to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles.

Judgment: Compliant

Regulation 23: Governance and management

Some of the management systems in place to ensure that the service was safe and effectively monitored were not fully effective. This was evidenced by:

- inadequate oversight of fire precautions, assessment and care planning and residents rights.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an up-to-date policy in place for the management of complaints. Records demonstrated that complaints documented within the centre's complaint log were managed in line with the requirements of the regulation.

Judgment: Compliant

Quality and safety

The findings on the day of inspection were that the provider was delivering satisfactory care to residents, in line with their assessed needs Residents had good access to health care services, including general practitioners (GP), dietitian and speech and language therapy services. Clinical risks such as falls and nutrition were well-monitored. Residents generally spoke highly of the quality of the service provided. However, this inspection found that assessment and care planning residents rights, premises, fire precautions and medicines management did not fully align with the requirements of the regulations.

A pre-admission assessment was carried out by the person in charge to ensure the centre could meet the residents' needs. Records showed that nursing staff used validated tools to carry out assessments of residents' needs upon admission to the centre. These assessments included the risk of falls, malnutrition, assessment of cognition, and dependency levels. The outcomes of these assessments were used to

develop an individualised care plan for each resident. However, some care plans were not always updated to reflect the current care needs of the residents'. For example, a residents end of life care plan did not contain the most up-to-date information in relation to the residents' wishes This posed a risk that this information would not be communicated to all staff.

The inspector observed that there was a generally a rights-based approach to care; residents lived in an unrestricted manner according to their needs and capabilities. However, the provider had not ensured that there were consistent opportunities for residents to participate in meaningful activities on a daily basis, in accordance with their interests and capacities.

The centre was found to be well-lit and warm. Residents' bedroom accommodation was individually personalised. A programme of maintenance work was ongoing. However, some areas areas of the centre did not align with the requirements of Regulation 17: Premises. For example, the inspector found that the layout and design of the premises met the individual and collective needs of residents with the exception of the configuration of two shared bedrooms. This is described under Regulation 17: Premises.

A review of fire precautions found that arrangements were in place for the testing and maintenance of the fire alarm system, emergency lighting and fire-fighting equipment. Staff were knowledgeable with regard to safe and timely evacuation of residents in the event of a fire emergency. However, deficits were identified in relation to several utility room doors which were not identified in the routine fire checks conducted in the centre. This is detailed under Regulation 28: Fire precautions.

There was a centre-specific policy in place to guide nurses on the management of medicines. Controlled drug balances were checked at each shift change as required by regulations and in line with the centre's policy on medication management. However, some unused medicines, were not stored in securely. This is discussed under Regulation 29: Medicines and pharmaceutical services.

Residents were supported to attend a general practitioner (GP) from the local practice and out of hours GP services were available when required. Residents had good access to physiotherapy, occupational therapy, dieticians, tissue viability nursing, palliative care input and speech and language therapy, where required.

There was a low use of restrictive practice in the centre, and restrictive practices were appropriately risk-assessed and monitored. Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) received evidence-based care and support from staff that was kind and respectful.

The provider had measures in place to safeguard residents from abuse. The provider acted as pension agent for seven residents and pensions were paid into a separate resident bank account. Records of each resident's payments and surplus amounts were maintained and made available to review. A safeguarding policy provided

guidance to staff with regard to protecting residents from the risk of abuse and training records identified that staff had completed up-to-date training in the prevention, detection and response to abuse.

Advocacy services were available to residents and there was evidence that residents were supported to avail of these services, as needed. Residents had access to religious services and resources, and they were supported to practice their religious faiths in the centre.

Visitors were observed coming and going to the centre on the day of inspection. Residents were able to meet with visitors in private or in the communal spaces throughout the centre.

Regulation 11: Visits

Visits by residents' family and friends were facilitated without restriction. Residents were able to receive visitors in a variety of locations including their bedrooms and dedicated areas within the centre.

Judgment: Compliant

Regulation 17: Premises

The designated centre did not conform to the matters set out in Schedule 6 of the regulations in the following areas;

- Some surfaces including wooden finishes in the clinical room and clean linen stored were unfinished and worn, and did not facilitate effective cleaning.
- Flooring was damaged in one resident bedroom.
- Sharps containers were not stored securely in the sluice room.
- A small number of shower heads were broken.
- The layout of two bedrooms designated to accommodate two residents did not meet the needs of residents occupying the bedrooms. For example, while there was sufficient personal space for each resident, the layout of the room meant that the bedroom was not suitable for residents who required the use of a hoist for transfer.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

A review of documentation found that when residents were transferred to hospital from the designated centre, relevant information was provided to the receiving hospital. Upon residents' return to the designated centre, staff ensured that all relevant clinical information was obtained from the discharging service or hospital. Copies of transfer documents were filed in the residents charts.

Judgment: Compliant

Regulation 28: Fire precautions

Some inadequate fire precautions were observed on this inspection. For example:

- At the main entrance door, the inspector identified a gas line and shut-off lever without a protected cage around the lever. The lack of a cage created a risk of the lever being tampered with.
- A slide bolt was fitted on the inside of one communal room door. This may create a risk of persons becoming trapped inside a room in the event of a fire in the centre.

Arrangements in place to ensure that the containment of fire and smoke in the event of an emergency was not adequate.

- A fire door to one communal room was wedged open, which could negatively impact on the containment of flame and smoke in the event of a fire.
- Three utility room fire doors had visible gaps when closed which could also negatively impact on the containment of flame and smoke in the event of a fire. The deficits to the doors were not identified in the routine fire checks conducted in the centre. A full assessment of all the fire doors is required to be completed by a competent person.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge failed to ensure that medicinal products which were no longer in use by a resident was stored in secure manner in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of residents assessment and care plans found that some care plans had not been developed as required under Regulation 5.

- A resident who had a pressure related wound did not have a care plan developed, based on an assessment of need. This meant that staff did not have access to a care plan regarding care delivery.

A review of residents assessment and care plans found that some care plans had not been reviewed as required under Regulation 5. This was evidenced by:

- A residents end of life care plan did not contain the most up-to-date information in relation to the residents' wishes. This posed a risk that this information would not be communicated to all staff.
- The interventions in place to weigh a resident who had increased mobility care needs were not recorded in their plan of care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of their choice. Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy, and occupational therapy through a system of referral.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) were observed to receive care and support from staff that was person-centred and respectful. Staff had up-to-date knowledge to support residents to manage their responsive behaviours.

The provider promoted a restraint-free environment in the centre in line with local and national policy. The provider had regularly reviewed the use of restrictive practises to ensure appropriate usage.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. A safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The provider did not ensure that residents were provided with opportunities to participate in activities in accordance with their interests and capacities on a consistent basis. For example:

- The inspector observed that a number of residents did not take part in the activity provided on the day of inspection. When asked, some residents told the inspector they were not interested in the choice of activities provided.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cratloe Nursing Home OSV-0005393

Inspection ID: MON-0050407

Date of inspection: 29/04/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Social Care Activities for all residents is imperative to our holistic care process within the NH, so additional staffing (with the appropriate competence and training) will be implemented (to cover AL arrangements) to ensure the continuation of holistic care services for all Residents living in the centre. PIC/Management Team to implement plan update as of 30/06/2026. The Senior Nursing Team will ensure that all Residents have a Meaningful Activity Assessment completed by 31/07/2026 to ensure all Residents "needs, preferences and mental capacities" are catered for in the design of the Daily/Weekly/Monthly activities program being developed within the centre. Activities Audit for Q3 is due to be completed by 31/07/2026, results of same to be discussed at the next Residents/Family Meeting planned for 06/08/2026, thereafter, a new Activity Schedule will be prepared for all residents once consensus decisions agreed upon with all Residents (including their families). New Activity Program/schedule to be ready for implementation by 31/08/2026.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

Re additional oversight required in Fire Precautions, please see compliance action plan under Regulation 28.

Re Resident Assessment, Care Planning & Medication Management, please see compliance action planning under regulations 5 & 29

Re Resident Rights, please see compliance action plan under regulation 15/9 Staffing and Residents Rights.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The doors of the Medicine Cupboards within the Clinical Room have been commissioned to be upgraded with external contractor, due for completion by 31/07/2026 and the MDF Shelves within the Clean Linen Store will be sanded and painted by the internal maintenance team, also due for completion by 31/07/2026.

The damaged flooring in one Residents Bedroom has been repaired by the internal maintenance team on 10/06/2026 and the Sharps containers within the sluice room have now been securely stored by the used of "clips" obtained from contracted company (as of 08/05/2026). The broken Shower Heads have also been replaced by thr internal maintenance team as of 08/05/2026.

The Registered Provider agreed with the HIQA Officer that Rooms 12 & 13 within the centre will be used for Residents with assessed low to medium dependency care requirements as of (26/06/2026) and the Statement of Purpose and Function has been updated accordingly.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

A new Fire Box has been reimplemented around the gas shut-off valve to ensure it is not tampered with. For added security the gas line has been labeled with a GAS Warning Sign. These precautions were reimplemented as of 08/05/2026.

The slide-bolt fitted inside communal room door has been removed as of 08/05/2026. And the Dining Room Door that was wedged open during the HIQA Officer Inspection on 29/04/2026 has had a new magnetic-locked by fitted (08/05/2026) and which now closes automatically on the activation of the Fire Alarm.

A competent Fire Officer has been commissioned to complete a full Fire Door Assessment within the Centre (due by 31/07/2026) and an appropriate safety action plan will be implemented thereafter on competition of this assessment by a competent officer.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

The PIC will discuss the new/updated Medication Management Policy with her Nursing Team at their next Nurses Meeting planned for 19/06/2026 and will reiterate the policy on the storage, dispensing and return of medicines within the center.

The Nursing Governance and Compliance Officer is due to complete a Medication Management Audit by 30/06/2026, where feedback and action planning will be provided to the PIC and the Nursing Team in relation to the results of the Audit completed.

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:

Our Nursing Governance & Compliance Officer (previous PIC in organization) has been promoted to new role within company since October 2025 to support and guide the Nursing Team as a whole with their roles and functions. This senior nursing professional will assist the PIC and DoN complete the supervision and monitoring of Clinical Assessment, Care Planning and Medication Management of all individual resident care processes within the NH with individual named nurses.

The PIC will be assisted by the DoN to complete clinical supervision daily/weekly with the

Nursing Team ensuring appropriate levels of supervision and monitoring is achieved and which will reflect in improved standards of personal care/assessments and Clinical Documentation for all residents. The Governance & Compliance Officer will complete Clinical Supervision Training with the nursing team by 29/05/2026 to assist them in understanding their role and function as Clinical Managers and as Named Nurses.

The Nursing Governance & Compliance Officer is due to complete Clinical Audits on Assessment & Care Planning (Nursing Documentation), Medication Management and management of Restrictive Practice Procedures within the NH by the 30/06/2026, which will provide additional support measures for all the Nursing Team. Action planning will follow from these clinical audits with all Named Nurses to improve all standards of Care Processes within the centre.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Please see Compliance Plan as documented in Regulation 15 above.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/07/2026
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 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service	Substantially Compliant	Yellow	30/06/2026

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	31/07/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/07/2026
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will not cause danger to public health or risk to the environment and	Substantially Compliant	Yellow	30/06/2026

	will ensure that the product concerned can no longer be used as a medicinal product.			
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	30/06/2026
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.	Substantially Compliant	Yellow	30/06/2026
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	31/07/2026