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:	SignaCare Killerig
Name of provider:	Signacare Killerig Ltd
Address of centre:	Killerig, Carlow
Type of inspection:	Short Notice Announced
Date of inspection:	09 March 2026
Centre ID:	OSV-0005454
Fieldwork ID:	MON-0048954

About the designated centre

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

SignaCare Killerig Nursing Home is situated a short driving distance from Tullow town in County Carlow. The centre provides accommodation for 55 residents. It caters for both male and female residents aged over 18 years of age. Residents are accommodated in 45 single bedrooms and 5 twin rooms, each with ensuite shower, toilet and wash basin facilities. Bedrooms are located on the ground, first and second floor. The ground floor mostly consists of spacious communal areas and various services such as catering, laundry and treatment rooms. Care services provided at SignaCare Killerig include residential care, convalescence, respite and palliative care for residents. The provider employs a team of staff in the centre to meet residents' needs. This team consists of registered nurses, care assistants, an activity coordinator, maintenance, housekeeping and catering staff. According to their statement of purpose, value is placed on the uniqueness of each individual and the centre is guided by a commitment to excellence that ensures every resident will enjoy passionate and professional care. They aim to enhance the ability of residents to participate in and contribute to daily life. Facilitating residents' independence and choice in how they plan their daily lives. The centre aims to provide a person centred approach to care where staff will endeavour at all times to deliver quality care informed by best practice and complying with all relevant standards and legislation ensuring the residents are involved in all aspects of planning and decision making.

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
Monday 9 March 2026	15:00hrs to 23:15hrs	Laurena Guinan	Lead
Monday 9 March 2026	15:00hrs to 23:15hrs	Niamh Moore	Support

What residents told us and what inspectors observed

Inspectors spoke with residents and spent time in communal areas and walking around the centre observing interactions between staff and residents and saw that these interactions were calm and respectful. Residents who lived in SignaCare Killerig Nursing Home told the inspectors that the staff were attentive to their needs, and it was a good place to live. One resident described the centre as nearly as good as home. However, some residents reported that at times, there were delays to receiving care.

This was an unannounced risk inspection which took place over one day by two inspectors, focusing on the late afternoon into the evening time to review staffing levels and the supervision of residents' care.

Inspectors arrived to the centre at 15:00pm, and were met by the receptionist to sign in. Following a brief discussion with the person in charge, inspectors completed a walk around of the premises. The designated centre was registered for 55 residents with 51 residents on the day of the inspection.

The centre was purpose-built and spread over three floors with resident accommodation on all three floors, which were accessible by stairs and lift. On the ground floor, there was a large reception area with a coffee dock that residents and their visitors could use. Four interlinked but separate communal areas on this floor were all seen to be well used on the evening of the inspection. The quiet room had gentle music playing on the TV, and residents were relaxing here under the supervision of staff. The large living room had a more lively atmosphere, with residents being offered a choice of snacks and drinks with the assistance of staff, and religious music playing on the TV. Kitchen staff had prepared a birthday cake for one of the residents. Other residents commented on how appealing the cake looked, and were later seen to enjoy tasting it. The dining room was clean and tidy, but the written menu on display on the board differed from the pictorial choices. The activity room was bright and clean, but was without a call-bell and a resident who appeared confused was unsupervised in this room. Inspectors asked staff to assist the resident. They confirmed that the resident could become agitated and required supervision, and they escorted the resident to the living room in a gentle manner. Across the corridor from the dining room, there was a room decorated to resemble an old-style bar. Staff reported that this was frequently used by residents, although the inspectors saw an opened bottle of beer on the bar, and the door was propped open with a chair. This was brought to the attention of staff who removed the bottle and closed the door.

There was accommodation for ten residents on the ground floor, and one health care assistant was allocated to supervise this area with support from the nurse on the second floor. However, at times during the inspection, inspectors did not see any staff available for residents on this corridor. This will be discussed later in the

report. The first and second floors also had resident accommodation and these floors were seen to have staff available to respond to call-bells, supervise and assist residents.

The centre provides accommodation for 55 residents in 45 single and five-twin bedrooms. Residents' bedrooms were clean, of a sufficient size and layout, and many residents and their families had personalised their bedroom spaces with their individual belongings such as plants, ornaments, photos, and with some bedrooms containing a fridge. Residents who spoke with the inspectors said that they were happy with their bedrooms.

A recent satisfaction survey was completed with residents during the period of December 2025 to February 2026. Inspectors saw that residents reported to be satisfied with their access to communal areas, their bedrooms, the support they received from staff, the provision of their choice in times to get up and go to bed, and choice of meals. The main areas that residents reported dissatisfaction with were in relation to the laundry provision and security of their belongings. This was discussed with management who were aware of concerns relating to laundry provisions. They had been in contact with the laundry provider to improve the system and there had been a reduction in complaints from residents as a result. However, there were plans to provide an on-site laundry service to ensure better oversight of the care of residents' clothes.

Inspectors spoke with one visitor who expressed that they were very happy with the care their loved one received within the centre and stated they had no complaints at all.

Inspectors observed the dining experience for the evening meal, and saw that many residents were eating in the dining room, while some chose to eat in their bedrooms. During this meal, residents were given a choice of two options, such as sausages, hash browns and beans, or creamed rice pudding. Staff served residents in their bedrooms from bain-maries to ensure the meals were served hot. There were adequate levels of staff to support residents, and those who required assistance with their meals received support from staff in a respectful and dignified manner. Overall, residents who spoke with the inspectors were complimentary regarding the food provided, however one resident expressed dissatisfaction, and management were addressing this feedback.

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 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

There was a clearly defined management structure in place and while there were many good management systems observed, some were found to be ineffective, particularly in relation to the oversight and provision of adequate resources to run a consistent service for all residents.

This was an unannounced inspection 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 unsolicited information and statutory notifications submitted to the Chief Inspector since the last inspection in August 2025.

The registered provider was Signacare Killerig Limited, which is part of the Virtue Integrated Care group. A regional manager was in place to provide managerial support to the person in charge. The person in charge was responsible for the local day-to-day operations in the centre and was supported in the role by the assistant director of nursing and a clinical nurse manager.

Inspectors were told that on the day of the inspection there was a number of staff vacancies which were in the final recruitment stages, and being covered by temporary staff in the interim.

Inspectors observed throughout the inspection that staff were busy attending to residents' needs. On the day of the inspection, the skill-mix and allocations of staff did not have full regard for the dependency needs and the layout of the centre. As a result, residents on the ground floor did not have access to the same consistency of care as residents on the first and second floors, despite staff being committed to supporting the safety and welfare of residents. During this inspection, management told inspectors they were aware of the particular weaknesses identified in sufficient staffing levels, but at the time, there was no plan in place to address this.

Inspectors found that there was good access to training and appropriate measures of formal supervision in place such as induction forms and appraisals. However, staff were not consistently supervised in an appropriate and effective manner to ensure adequate oversight of the delivery of direct care to residents. This is further discussed under Regulation 16: Training and staff development.

Inspectors saw evidence of management systems in place such as regular meetings, auditing, and key clinical and non-clinical data being trended. In addition, there was an annual report on the quality and safety of care of residents in 2025 and a quality improvement plan for 2026. However, despite these good practices, there was no evidence of effective oversight systems to identify all areas for improvement, and where areas of improvement were identified, there was insufficient evidence to demonstrate that all necessary actions were progressed.This is further discussed under Regulation 23: Governance and Management.

There was an accessible complaints procedure in place. There was evidence of a culture of openness that welcomed feedback and the raising of concerns. Inspectors

found that from a review of a sample of closed complaints, these were overall managed in line with their policy.

Regulation 15: Staffing

From a review of the rosters and allocation duties, inspectors saw there were two nurses on duty day and night. One nurse was allocated to the first floor, and one nurse was allocated to both the ground floor and second floor. The skill-mix and allocation of staff on the ground floor was not seen to be sufficient for the needs of the residents as evidenced by:

- Delivery of appropriate post-fall care was not always adhered to on this floor in the same manner as on the first and second floors, and in line with the centre's own policy.
- The arrangements in place to manage residents' skin integrity on this floor were not consistent with the first and second floors, which resulted in further deterioration in skin condition.

Additionally, the inspectors were not provided with evidence that dependency levels informed the skill-mix and staffing levels on each floor, which the provider previously committed to in a provider assurance report submitted to the Office of the Chief Inspector. For example, on the day of the inspection, 52% of residents were assessed as being maximum dependency. These residents typically required two staff to support them with their activities of daily living. A further 18% were assessed as being high dependency. However, inspectors observed inconsistent delivery of care across all floors, and some residents spoken with told inspectors that at times staff were slow to respond to their needs. Nurses spoken with also confirmed that they often had difficulty completing all clinical duties, specifically medication administration and wound care.

Judgment: Not compliant

Regulation 16: Training and staff development

The systems in place to ensure staff were appropriately supervised were not robust as evidenced by:

- Not all staff who worked the night shift were familiar with the care needs of all residents. For example, the residents who required regular repositioning or enhanced supervision. Inspectors observed that three residents, who required repositioning every two hours and had been assisted to bed at approximately 18:30, had not been repositioned by 22:45.

- The handover from night staff to day staff did not provide key information regarding an incident in which a resident who was at a high risk of falls was found walking on the corridor because their sensor alarm had not sounded.
- Delays in the escalation of compromised skin integrity was observed on two occasions on the ground floor.

Judgment: Substantially compliant

Regulation 23: Governance and management

The designated centre did not have sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. For example, the assistant director of nursing was working four days a week and the clinical nurse manager was working two days a week, which was not in line with the full-time hours outlined within the statement of purpose dated April 2025.

Gaps were identified in the oversight systems in place to ensure that all areas of the service were consistent and effectively monitored. For example:

- The registered provider had not ensured that commitments provided to the Chief Inspector through a provider assurance report had been fully actioned. For example, there was no evidence that dependency levels were being regularly reviewed to assess safe staffing levels.
- The providers' arrangements for staff allocation and supervision were not sufficiently robust to ensure the assessed needs of residents were being met.
- The oversight systems to ensure that investigations following an incident were carried out in a timely manner were insufficient. The inspectors requested that an investigation report into an incident be submitted following the inspection, however, this report was not provided. Instead, a summary report completed four months after the incident and in response to this request was submitted. Inspectors found that this summary was not consistent with information provided to inspectors during the inspection. The summary did not demonstrate that a robust investigation had been carried out, or that all risks had been mitigated. For example, not all staff involved in the incident were interviewed, with five out of seven staff interviewed, and there was insufficient oversight to ensure that residents' dependency levels were considered when allocating staff breaks.
- Despite feedback from residents and staff that the external laundry was a concern, and this issue was discussed in both governance and residents meetings since February 2025, there was no time-bound action plan in place to address the concerns raised.
- While there was trending of incidents, these did not consider the location within the centre and therefore did not provide assurance that key aspects of risk factors were being effectively reviewed. For example, inspectors identified a gap in oversight arising from incidents and feedback on the ground floor that had not been identified by the provider.

- Oversight systems in place had not ensured that all areas of the premises met the requirements of Schedule 6. For example:
    - there was no call-bell in the activity room.
    - the bar area had the door held open with a chair because the automatic door stopper was not working.
    - a sensor alarm was activating in error, causing a noise disturbance in the evening time.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications had not been submitted to the Chief Inspector within the required time frame. This was evidenced by:

- Two notifications had been submitted two days late.
- One notification had been submitted six days late.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors saw evidence where residents were supported to make complaints through residents' meetings. Records of complaints were available for review. The inspectors reviewed a number of complaints received since the last inspection and found these were investigated with conclusions, which included recommended improvements.

Judgment: Compliant

Quality and safety

It was evident that staff were striving to deliver good quality care to residents. Residents provided positive feedback on the kindness of staff and said they were given choice on how they spent their day. Inspectors found that staff and the person in charge were known to residents by name and were knowledgeable of residents' individual needs. However, there were gaps in the delivery of care on the ground floor in comparison to the first and second floors.

The inspectors reviewed a sample of care plans from each floor with a focus on wound care and post-fall care. Residents on the first and second floors had prompt identification of deterioration in skin integrity, with referral to allied health professionals as required, and recommendations documented and followed. However, a resident on the ground floor who had a history of impaired skin integrity had two instances where pressure ulcers were not identified in a timely manner. For example, one pressure ulcer had not been documented until it had progressed to a stage 3. Additionally, two residents on the ground floor did not have post-fall care administered in line with best practice and with the centre's own policy. For example, neurological observations were not conducted at the recommended intervals, and the nursing records for one of the residents, prior to and including their transfer to hospital, were incomplete. This will be discussed under Regulation 5: Individual assessment and care plan.

Residents had access to fresh drinking water. Choice was offered at all mealtimes and adequate quantities of food and drink were seen to be provided. Following the last inspection, an improvement was seen in the delivery of meals to residents who were dining in their bedrooms. Inspectors saw that the evening meals were delivered hot on the day of the inspection, and residents spoken with confirmed that there were no issues with the temperature of the food provided. Residents also confirmed that they were provided with adequate quantities of food, and their choices and preferences were always accommodated.

Regulation 18: Food and nutrition

A varied menu was available daily providing a range of choices to all residents, including those on a modified diet. There were sufficient numbers of staff to assist residents at mealtimes. Residents were monitored for weight loss and were provided with access to dietetic services when required.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While the inspectors saw care plans that were detailed and person-centred, the assessment of residents on the ground floor was not always sufficient to ensure their care plans reflected their current condition and directed staff in how to care for the resident. This was evidenced by:

- The deterioration of a resident's skin integrity was not appropriately assessed, resulting in a pressure ulcer progressing to an advanced stage before being referred for treatment.

- The care plan for a resident with an impaired pressure area following hospital discharge had not been appropriately reviewed, resulting in further deterioration of the area before it was correctly assessed and treated.
- A resident who had a history of falls was not reassessed for additional falls prevention measures.

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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant

Compliance Plan for SignaCare Killerig OSV-0005454

Inspection ID: MON-0048954

Date of inspection: 09/03/2026

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: - The PIC and the Regional Manager review dependency levels of residents in conjunction with staffing allocations weekly and as part of the G&M meeting. The staffing skill-mix and allocations are being implemented and increased based on: Occupancy, Clinical KPI's, Resident dependency levels, Clinical acuity, Cognitive and behavioural support needs, Number of residents requiring two-person assistance, Environmental layout and oversight requirements of each floor. Adjustments to the staffing numbers, skill mix and allocations are considered daily by the PIC and/or ADON based on current status of residents e.g. at end of life, increased falls, skin integrity concerns, increased responsive behaviours in any given area or day. - Post-fall care has been enhanced by the nursing team with additional training planned on post fall with the PIC and Regional Manager. Post fall care of residents is audited, trended and monitored by the PIC and ADON via weekly Clinical KPI's and by daily review of incidents inclusive of assessment and careplan evaluation. The regional manager includes Clinical KPI's of falls and skin integrity in the G&M meeting agenda which maintains increased oversight. - Physio and GP Assessments/Reviews are completed after every fall on their weekly visits to the centre, care plans and assessments are updated post MDT input to reflect changes. - The PIC has revised the trending of incidents to include the location (floor and room), time of the incident, occupancy of the floor and the staff allocated to the area at the time of the incident. The outcome of the trend analysis forms part of the clinical management team meeting, is communicated to staff, discussed with the regional manager and adjustments to staffing, allocations and oversight is acted upon as required. - Skin Bundles have been initiated and are completed by nurses on EpicCare to cover all residents across all floors and mitigate skin issues. Named nurses have been assigned to residents across day and night shifts to ensure that each resident's skin integrity is assessed 2–3 times per week. The ADON and/or CNM audit completion of the SSKIN bundle assessment twice a week. The assessment results will be trended and used in the PIC's review of staffing needs, allocation and skillmix on each floor. - Increased monitoring by the nurses to ensure that the supervision and quality of care	

of the residents on the ground floor is of a high standard. Nursing staff will ensure that the assessment, planning, delivery, and supervision of care for residents on the ground floor are appropriate, person-centred, and reflective of residents' assessed needs. Compliance will be supported through regular audit, supervision, and oversight to ensure continuous quality improvement. The nurses allocated to look after the ground and second floor will complete comfort and safety checks of each resident to ensure that residents repositioning, skin care and falls prevention is completed appropriately and effectively in line with the residents assessments and care plan.
- The allocated nurse to the ground and second floor during the day and night will complete the assigned SSKIN bundles and attend to the residents for each incident i.e post fall. Clinical oversight has increased on the ground floor with the ADON and CNM allocated to support the nurse with clinical care on week days. There is also a senior HCA allocated to the ground floor on each shift.
- Following G&M meetings the RPR is informed of any adjustments required or actioned by the regional manager at the weekly RPR operations meeting. The agenda for this meeting includes staffing and resident matters.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
- The PIC attends morning handovers Monday-Friday and ensures that all relevant information about: skin, health/mobility changes, falls, and family communication is passed on to the team. Handover audit's on night duty have shown a very comprehensive handover from day staff to night staff, and important information was relayed to night staff including residents already in bed and for repositioning, new admission and the planned admission for next day.
- Skin Bundles have been commenced and completed by nurses on Epiccare, to cover all residents across all floors and mitigate skin issues.
- Safety pauses are carried out 3 times per day. Two during day shift and one during night shift. The nurses meet with the HCA's to discuss the care provided to residents and any issues that may arise through the shift.
- Training will be arranged for staff in pressure ulcer prevention and management.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: - The staffing levels in the centre are now reflective of the SOP. - A second CNM has been in place since 06/04/26, this now meets what is reflected in our SOP. - New staff have commenced since inspection 2.5 WTE HCA's and 2 WTE Nurses. - Safety pauses are carried out 3 times per day. Two during day shift and one during night shift. The nurses meet with the HCA's to discuss the care provided to residents and any issues that may arise through the shift. - The PIC and the Regional Manager review dependency levels of residents in conjunction with staffing allocations weekly and as part of the G&M meeting. The staffing skill-mix and allocations are being implemented and increased based on: Occupancy, Clinical KPI's, Resident dependency levels, Clinical acuity, Cognitive and behavioural support needs, Number of residents requiring two-person assistance, Environmental layout and oversight requirements of each floor. Adjustments to the staffing numbers, skill mix and allocations are considered daily by the PIC and/or ADON based on the current status of residents e.g. at end of life, increased falls, skin integrity concerns, increased responsive behaviours in any given area or day. - All serious incidents are and will be investigated by the PIC. Further escalation will happen as appropriate before or following an investigation. An SIR will be completed for every serious incident that occurs in the centre involving residents or staff. This will be completed in line with the centres policy and procedures. - Monthly unannounced out of hours Spot check audits are completed by the PIC at different times of the day to ensure staff adherence to supervision and care of residents is being met across the centre over the 24 hour period in line with their assessed needs, best practice and the staff allocations. - Allocated break times have been reviewed and revised to ensure adequate staff are available to address resident needs throughout the day/night and these are being monitored by the clinical management team. - There have been no recent complaints from residents or staff regarding laundry. All issues in the past have been raised and resolved with the company providing service to the centre. The PIC will continue to monitor this outsourced service, and any future complaints will be addressed and resolved promptly to include a review of the laundry service and/or any QIP required. The last complaint received was in January 2026, this was resolved promptly to the complainant's satisfaction. - Incident trending processes have been strengthened to include detailed analysis by location, including floor level and number of residents per floor. This enables the identification of patterns, risks, and emerging themes in specific areas of the centre. Action plans are developed in response to identified trends, with staff assigned responsibility for each action. These actions are reviewed at the clinical management team meeting to ensure completion and effectiveness. This structured approach ensures that incident data is not only collected but used proactively to drive improvements in resident safety and quality of care. - While immediate actions have been taken to address identified issues (replacement of sensor alarms, repair of the door stopper, and installation of a call bell in the activities room), formal systems are in place to ensure the ongoing monitoring and maintenance of the premises. The PIC completes a daily safety check of the centre to include monitoring that all residents and staff have access to call bell's in each area, that the functioning of	

doors are appropriate and effective and that any faulty equipment observed is reported and actioned immediately. A planned preventative maintenance schedule is in place to inspect equipment, environmental safety features, and all areas of the centre, this is completed by the maintenance person with oversight from the facilities manager. This is supported by routine environmental and health and safety audits, which are completed on a scheduled basis. A maintenance log and tracking system is in operation, where all defects or repair requirements are recorded and tracked through to completion. The PIC monitors completions and follows up with maintenance for updates. Any outstanding issues are reviewed regularly at management and governance meetings to ensure accountability and follow-up. The weekly G&M meeting between the RPR and regional manager includes facilities and maintenance items for escalation
- Additional stock of bed & chair sensors are available in the centre to replace any faulty equipment immediately, this stock is monitored by the maintenance person who will inform the PIC when the stock is low for replacements to be ordered.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All notifications will be sent to the inspector within 2 working days

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:
- Increased monitoring by the nurses to ensure that the supervision and quality of care of the residents on the ground floor is of a high standard. Nursing staff will ensure that the assessment, planning, delivery, and supervision of care for residents on the ground floor are appropriate, person-centred, and reflective of residents' assessed needs. Compliance will be supported through regular audit, supervision, and oversight to ensure continuous quality improvement. The nurses allocated to look after the ground and second floor will complete comfort and safety checks of each resident to ensure that residents repositioning, skin care and falls prevention is completed appropriately and effectively in line with the residents assessments and care plan.
- SSKIN bundles have been implemented for all residents. Named nurses have been assigned to residents across day and night shifts to ensure that each resident's skin integrity is assessed 2–3 times per week. This supports the early identification and timely

management of any skin concerns. The ADON and/or CNM audit completion of the SSKIN bundle assessment twice a week. The assessment results will be trended and used in the PIC's review of staffing needs, allocation and skillmix on each floor.
- Training is scheduled for Nurses and HCA's on pressure ulcer prevention and management. This will be completed in July 2026 with additional training planned for Q3 2026
- The nursing home has a TVN service available to review residents wounds and the nursing team will refer the residents for review for all new wounds and when they note deterioration. This will be documented in the resident's care plan.
- Physio and GP Assessments/Reviews are completed after every fall on their weekly visits to the centre, care plans and assessments are updated post MDT input to reflect changes. Additional falls prevention measures will be explored for all residents who have a history of falls based on their falls assessment. The ADON and/or CNM review all incidents to include for example post fall observations, neuro obs and referrals to MDT. Compliance with post falls process is audited weekly by the PIC as part of KPI monitoring.
- Safety pauses are carried out 3 times per day. Two during day shift and one during night shift. The nurses meet with the HCA's to discuss the care provided to residents and any issues that may arise through the shift.

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.	Not Compliant	Orange	30/04/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/04/2026

Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/04/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	31/03/2026
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 accordance with paragraph (2).	Substantially Compliant	Yellow	31/07/2026
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	Substantially Compliant	Yellow	30/04/2026

	where appropriate that resident's family.			