



**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:	Cobh Community Hospital
Name of provider:	Cobh Community Hospital
Address of centre:	Aileen Terrace, Cobh, Cork
Type of inspection:	Unannounced
Date of inspection:	13 July 2026
Centre ID:	OSV-0000558
Fieldwork ID:	MON-0051034

About the designated centre

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

Cobh Community Hospital was established in 1908. It is run by a voluntary Board of Management and cares for 44 older adults. The "Friends of Cobh Hospital" are involved in fund raising for the hospital. Medical care is provided by a team of local doctors and a pharmacist is available to residents and staff. The older and main part of the hospital is laid out over three floor levels. The ground floor is split into two levels with the upper level accessible via a platform type lift or by a stairs consisting of six steps. Bedroom accommodation on the ground floor comprised four single bedrooms and two twin bedrooms. Bedroom accommodation on the upper level of the ground floor comprises one single en-suite bedroom and one four-bedded en-suite room. Bedroom accommodation on the first floor comprises three single bedrooms, four twin bedrooms and two four-bedded rooms. A new extension accessible through a corridor consists of 12 single en- suite bedrooms. The second floor is used primarily as office space. The first and second floors are accessible by a lift and stairs. Communal space available to residents comprises a large day room with dining tables and chairs, a separate dining room on Bluebell, conservatory, quiet reflection room, a quiet relaxation room called 'The Snug'. Outdoor spaces include a large mature sensory garden, a balcony area off the dining room on Bluebell and courtyard by the conservatory. The centre provides 24hrs nursing care to long and short stay residents, of all dependency levels.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40
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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 13 July 2026	09:00hrs to 17:30hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over one day in Cobh Community Hospital. The inspector met many of the residents on inspection and two relatives. Residents gave positive feedback about the centre and were complimentary about the care provided; relatives said that the service was exceptional and they would be 'lost without it'. One resident said that they find the staff wonderful, but of late, there is a shortage of staff as they are long waiting times to be assisted, for example, 'going to the bathroom'. Other concerns were identified on inspection included oversight of the service and evidence of this will be detailed throughout the report.

Cobh Community Hospital is located in the town of Cobh and is registered to accommodate 44 residents, of which 22 were long-stay residents and 22 short-stay respite and convalescence care residents.

The suggestion box, registration certificate, advocacy and complaints information were displayed in the main hallway along with other reading material such as the residents' guide, statement of purpose, previous inspection reports, and health and safety statement; the defibrillator is located here.

The building is laid out over two floors and a mezzanine level. Bedroom accommodation comprises single, twin and multi-occupancy four-bedded rooms. Some bedrooms were seen to be personalised. Some residents had access to double wardrobe personal storage space, while others had a single wardrobe. Additional double wardrobes were installed following the inspection. While residents had a locker, some were inaccessible to residents from their bed as they were located at the far side of the room. In one twin bedroom, a resident's denture carton was seen to be stored on the hand wash sink. Some residents did not have access to a television (TV) in their bedroom, but this was addressed immediately following the inspection. Privacy screens in bedrooms were heavy, cumbersome and had several brakes to be released so they could not be used independently by residents. These were all repeat findings and are discussed further in the report.

There was directional signage to inform residents of rooms such as the Rose Café dining room for example, to help minimise disorientation. Communal rooms comprise a large day room with dining tables, armchairs, and a kitchenette; there is a separate dining room on Bluebell; the reflection room and a quiet room called 'The Snug' are located on the main corridor, and a conservatory quiet room on Bluebell. Previously, the conservatory was cluttered with old furniture; this was removed and the space was much more accessible and pleasant for residents.

While the activities co-ordinator explained the day's activities, this detail was not displayed on the activities notice board to inform residents of the events of the day. The activities observed included mass being live-streamed from the local church in the morning followed by a concert on the TV. Bingo was played in the afternoon at

2:30pm. Visitors were seen coming and going throughout the day and were welcomed by staff in a social manner.

Residents had access to a variety of outdoor spaces such as the larger mature sensory garden with walkways and seating, a smaller patio area outside a conservatory, and a balcony which could be accessed from the dining room on Bluebell. One resident spoken with was sitting outside on the balcony; they bring out their radio and listen to the local channel. They explained to the inspector the sights seen from the balcony, such as the Cathedral, their old school and the beautiful views of the harbour. Other residents were seen ambling out to the sensory garden independently, enjoying the fresh air and sunshine.

Serving of the main meal of the day commenced at 12:30hrs and meals looked appetising and residents reported that the quality of food was good and there was good choice. Residents were assisted in accordance with their needs, and staff were seen to actively engage with residents. The dining areas enabled social interaction between residents, for example, there were two large tables, each facilitating eight residents comfortably, and residents were observed to meet up with their friends, chat and catch up. Snacks and drinks were offered to residents throughout the day. Later, tea was served at 16:30hrs.

A new toilet was being built opposite the main day room and would be easily accessible from the day room. As this was being built on the site of the external smoking shelter, it was reported that a new fit-for-purpose smoking shelter would be installed in the enclosed garden, with the appropriate safety features. Nonetheless, there is another smoking area as part of Bluebell. Currently, there are no residents in either Daffodil or Fushia that smoke.

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

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) Regulations 2013 (as amended), as well as to inform the renewal of registration process.

The person in charge was on statutory annual leave and was unable to attend the inspection. The assistant director of nursing and two CNMs facilitated the regulator, and the person representing the registered provider attended the feedback at the end of the inspection.

Two immediate actions were issued on inspection: one related to the absence of professional registration PINs for four nurses, and the second related to fire safety concerns as assurances were not provided regarding safe and timely evacuation of residents. Following the inspection, copies of the nurses' current registration PINs were submitted to the regulator. While a simulated evacuation record was submitted following the inspection, it demonstrated three residents involved in the simulated evacuation, however, the largest compartment with seven had not been evacuated, so assurances remained wanting. A further report simulating the evacuation of seven residents was submitted; this report included actions and improvements required including repeating the evacuations to ensure staff familiarity with evacuation requirements.

The last inspection 01 April 2026 findings showed concerns regarding the governance and management of the service with non-compliance in regulations relating to governance and management, staffing, and fire safety; other regulations demonstrated repeat findings over several inspections including regulations associated with personal possessions, residents' rights, and infection control. Additional findings on this inspection related to oversight of Schedule 2 records to be maintained for each member of staff regarding current professional registrations, as detailed above. Following a recent incident where a resident absconded, the notification submitted to the regulator confirmed remedial actions taken such as the installation of a gate, connected to the fire alarm with coded access, however, this was not evidenced on inspection. Review of a safeguarding incident investigation relating to another notification demonstrated that the associated policies were not implemented to support the safety and well-being of residents. Thus, management systems in place, to monitor and ensure the quality and safety of care provided to residents continue to be of significant concern.

Actions from the previous inspection that were addressed included the directory of residents to ensure compliance with paragraph 3 of Schedule 3 of the regulations; personal emergency evacuation plans [PEEPS] now included the assistance residents would require for both day and night time evacuations; the dining experience for residents as deserts were now temperature checked before being served to residents to ensure they were the optimum temperature.

The schedule of audit had been updated following the findings of the last inspection, and implemented three weeks prior to this inspection. This schedule was more comprehensive and covered a much wider range of clinical topics to enable better monitoring of the service provided. The CNMs discussed this and assurances were provided that they were implementing the programme of audit, and explained that these would inform quality improvements.

Cobh Community Hospital is a voluntary hospital with a board of directors. One of the members of the board represents the registered provider (Cobh Community Hospital) for the purposes of regulation and registration. The management structure on site comprises the person in charge, assistant person in charge (ADON) and two clinical nurse managers (CNMs), however, that structure was due to change imminently with the departure of the ADON. The inspector was informed that the post of ADON will not be renewed, instead, another CNM post will be established to

facilitate a CNM per unit. This will require the statement of purpose to be updated to reflect the governance structure supporting the application to renew registration of Cobh Community Hospital. On site, the management team is supported by nurses, health-care assistants, catering, household, administration, maintenance and volunteers. There were 40 residents in the centre on the day of inspection.

As there were 22 short-stay residents, the care and administration burden on staff was augmented with such a high turn-over of admissions and discharges on a weekly basis, a review of the staffing roster was requested to ensure adequate support and supervision of residents. It was also reported to the inspector that there is a deficit of three nurses resulting in a high level of agency staff which impacts care delivery as well as care documentation.

Records were readily available to the inspector. The complaints procedure displayed was not in an easily accessible format and information relating to patient advocacy services (PAS) was not included as part of the complaints procedure displayed. A sample of complaints records were reviewed; while some information was included in these records, it was limited and did not reflect the specified regulatory requirements; these are further discussed under Regulation 34: Complaints procedure.

Regulation 14: Persons in charge

There is a person in charge in Cobh Community Hospital. They worked full time in the centre. They held the required management experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

As there is 22 short-stay residents, the care and administration burden on staff is augmented with such a high turn-over of admissions and discharges on a weekly basis. A review of the staffing roster was requested, including twilight hours, to ensure adequate support and supervision of residents. Residents reported longer waiting times to be assisted with care.

Regarding twilight hours:

- medication rounds on each unit commence following staff handover at 8pm, so the nurse is occupied with medication administration for some time. Consequently, HCAs are responsible for supervision of residents, comfort rounds with the possibility of residents requesting to go to bed. Currently, there are approximately 20 residents assessed as high to maximum dependency with many requiring two staff to provide assistance. One HCA on

their own would be unable to provide the necessary assistance to all residents on their units as well as provide supervision in communal areas.
Judgment: Not compliant
Regulation 19: Directory of residents
The directory of residents was updated to ensure regulatory compliance with the requirements of paragraph 3 Schedule 3.
Judgment: Compliant
Regulation 21: Records
There was lack of oversight of recruitment HR process. Action was required to ensure Schedule 2 records, Documents to be Held in Respect of the Person in Charge and for each Member of Staff, were in place prior to staff taking up employment in the centre: Staff files of four nurses reviewed did not have a current nursing registration certificate for 2026 on file to enable them work as a nurse, and other items were also missing as identified below: • one file had no registration certification on file, certification of nursing qualification or photographic identification • one nurse, while registered in 2024, had no updated certification on file since then • one nurse's last valid certification on file was 2023, and • the forth file viewed did not have any certification on file. These were all submitted following the inspection.
Judgment: Substantially compliant
Regulation 23: Governance and management
Many of the issues previously identified on previous inspections had not been actioned and additional findings of this inspection demonstrated ineffective governance and management to ensure the service is safe, appropriate, consistent, and effectively monitored:

- many of the deficits identified on the previous inspection of May 2025 and April 2026 were not addressed, despite compliance plans from the provider committing that they would be completed by 01 July 2026. These are highlighted in this report as repeat findings,
- there was a lack of oversight of fire safety precautions, which required an immediate action to be issued on inspection, and is further detailed under Regulation 28: Fire precautions
- there was a lack of oversight of Schedule 2 records, Documents to be Held in Respect of the Person in Charge and for each member of Staff, these were submitted to the regulator following the inspection
- there was a lack of oversight of a statutory notifications as some information submitted to the office of the Chief Inspector was inaccurate and provided misleading information regarding actions completed
- while a statutory notification was submitted regarding an allegation of neglect of care, the associated policies were not adhered with regarding the investigation, specialist expertise sought or consultation with other senior management to determine the outcome of the investigation,
- the mandated infection prevention and control national standards had not been implemented into practice, as detailed under Regulation 27: Infection control
- there was a lack of oversight of complaints management to ensure concerns raised would be timely and appropriately addressed.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure complaints were recorded and managed in accordance with specified regulatory requirements:

- complaints, actions taken on foot of a complaint, and outcomes of complaints were not fully and properly recorded
- the complaints procedure displayed did not have the necessary information to inform people on how to make a complaint, and it was not in an accessible format for all to understand
- information relating to Patient Advocacy Services [PAS] was not included in the complaints' procedure displayed as specified in the regulations.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Action was required to ensure Schedule 5 policies and procedures were implemented into practice as policies relating to safeguarding were not implemented:

- the policy relating to recruitment and HR protocols as detailed under Regulation 21: Records regarding documentation to be held in the centre pertaining to all staff employed in the centre
- the policy relating to safeguarding, as the investigation did not adhere with their stated policy to identify a named investigation team, seek specialist expertise, consult with other senior management to determine the outcome of the investigation, for example.

Judgment: Substantially compliant

Quality and safety

In general, staff were observed to be respectful and it was evident that the team knew residents well and were observed to actively engage with residents throughout the inspection.

Residents had timely access to general practitioners (GP), specialist services and health and social care professionals, such as physiotherapy, dietitian and speech and language, as required. Good oversight of residents' nutritional needs was evidenced with a weight analysis over the previous six months, with additional information showing timely referrals and actions taken to address residents' needs. The sample of care plan documentation was reviewed; it was identified that people admitted for short-stay occupancy did not have care plans to enable individualised care. This is further detailed under Regulation 5: Individual assessment and care plan.

Fire servicing records were seen to be up to date. Regarding fire safety, the inspector reviewed fire safety management and issues identified on the previous inspection that impacted residents' safety had not been actioned. Further concerns were identified on this inspection as detailed under Regulation 28: Fire precautions. The provider representative acknowledged these concerns, and ADON committed to undertaking a simulated evacuation following the inspection and weekly thereafter until such time as they were assured that all staff were familiar with the process.

The inspector found that while residents' right and choices were promoted, some issues were identified relating to their personal storage space and access to personal possessions which impacted their quality of life, and these are discussed under the relevant regulations.

Regulation 12: Personal possessions

Following the inspection, photographic evidence was submitted to the regulator showing additional double wardrobes for each residents to enable them have adequate space to store their clothing.

Judgment: Compliant

Regulation 18: Food and nutrition

Improvement was noted regarding the serving of meals to residents. Deserts were stored appropriately and served to residents at optimum temperatures. For example, cold deserts were no longer brought to the dining room with the main meal and left on the kitchenette worktop, they were stored in the fridge to ensure they were cold when served.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure that mandated infection prevention and control procedures consistent with the standards published by the Authority were in place and implemented by staff a number of these issues are repeat findings from the previous inspection:

- some clinical hand wash sinks were not compliant with current guidelines of HBN-10 as there was a metal outlet and this outlet was directly below the water flow
- the water outlets of some handwash sinks were seen to be visibly unclean
- there was no handwash sink in the household cleaners' room
- there were two identical stainless steel sinks in the sluice room on Daffodil, one was identified as the 'dirty' sink and the second as the 'clean hand wash' sink, there were two bedpan insets left in the clean hand wash sink awaiting cleaning
- two of the new clinical handwash sinks were very stained
- in one twin bedroom, a resident's denture carton was stored on the handwash sink which could lead to cross contamination.

Judgment: Not compliant

Regulation 28: Fire precautions

The following required attention to ensure compliance with fire safety precautions, as:

- records reviewed showed daily fire safety checks were usually completed Monday – Friday, however, records showed that fire safety checks were not routinely completed at weekends
- despite commitments provided following similar findings of the previous two inspections, and issue of an immediate action plan on the last inspection in April 2026 regarding simulated evacuations to ensure staff could respond in a timely manner to ensure the safe evacuation of residents, assurances were not provided on this inspection as a full compartment evacuation had not been completed with minimum staffing levels such as night duty staffing levels, aside from fire safety training
- emergency evacuation floor plans were displayed throughout the building, however, in general, they were not orientated to reflect their relative position in the centre so could be confusing when following an evacuation route.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required regarding residents' assessments and care planning documentation, as:

- there were no care plans for short-stay residents. Care documentation demonstrated that there was very little information detailed in the assessments to enable individualised care. The inspector was informed that 'short-stay' residents have the required care plan included as part of their assessment, however, there was such little detail in the assessment, the information could not direct personalised care or inform the care-planning process.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to medical and allied health services, and specialist services such as palliative care and gerontology for example. Access to speech and

language and dietician services had improved following change in service provider. Staff reported an improved service with little or no waiting times following referral.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure residents had access to meaningful activation, as:

- information displayed regarding daily activities was very limited even though staff reported an array of activities planned, so residents could not plan their day or know what to look forward to from one day to the next
- while it was reported that there was an array of activities scheduled, this was not seen during the inspection, with very little active interaction observed throughout the 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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cobh Community Hospital OSV-0000558

Inspection ID: MON-0051034

Date of inspection: 13/07/2026

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 current bed occupancy numbers have been reduced by 9, this is effective immediately to ensure safe staffing levels and in agreement with the HSE. The provider is actively pursuing the implementation of an alternative shift rota to include a post for Twilight Hours and staff have stated their agreement for this shift. This post will be in place before the provider reopens 9 x Short Stay Beds. In addition, the provider is awaiting Garda Vetting for 2 x additional Staff Nurse and 2 x Staff Nurse who have been on Long Term Sick Leave – 1 returned w/c 03/08/2026 and the 2nd will return on w/c 17th August, new admin x 1 commenced 10/08. Notification for change in PIC was submitted 14/08/26.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: This was resolved on 14th July and all documents were submitted to HIQA	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The deficits of the previous reports are now been fully addressed with robust direct involvement by BOM members in co-operation with the PIC and senior management. The	

BOM representatives are on site daily working on all outstanding deficits and failures identified.

We remain committed to sourcing Privacy Screens that uphold residents' freedom principles and promote individual autonomy.

Full compartment evacuations are now completed on a weekly basis and are fully documented for the following dates-

The inspector noted that fire safety checks were not completed at weekends. The Acting Nursing In Charge completes the checklist at weekends. New emergency evacuation floor plans are now in place at fire panels and are in preparation for rooms.

The provider submitted documents relating to staff files on 14th July 2026.

All submissions to HIQA will continue to be checked for factual accuracy before submission.

The provider has engaged an independent person to review the Trust in Care policy and the procedures to be followed and actioned.

IPC requirements will be fulfilled, and a contractor has been instructed to install the additional HPN10 sinks required, with an expected completion date of 30/09/26

Signage has been updated and put up in shared spaces to meet all residents' communication preferences.

The Complaints Policy is currently under review and will be updated by 30th September 2026.

Regulation 34: Complaints procedure	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

Signage has been updated and put up in shared spaces which meet all of the residents communication preferences

The Complaints Policy will be updated by 30th September 2026.

PAS is now referenced on this.

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: Records have been submitted by the Provider. The provider has engaged an independent person to review the Trust in Care policy and procedures to be followed.	
Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The inspector observed the use of the incorrect sink for bed pans; the hand wash sink is being removed and a HBN10 sink installed at the sluice room entrance. The IPC link practitioner will provide refresher training for staff, highlighting correct management of dirty receptacles in the sluice room, commencing 26/8/26. Daily observational checks. These measures will be subject to audit. and associated documentation IPC requirements will be fulfilled, and a contractor has been instructed to install the additional HPN10 sinks required, with an expected completion date of 30/09/26	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Full compartment evacuations are now completed on a weekly basis and are fully documented for the following dates: 14/07/26, 15/07/26, 20/07/26, 30/07/27, 05/08/26 and 13/08/26. These have been simulated with both day and night-time staffing levels. The inspector noted that fire safety checks were not completed at weekends. The Nurse in Charge completes out-of-hours fire safety checks and is delegated to complete them at weekends when maintenance staff are not present. Updated emergency evacuation floor plans are in place at fire panels and are in preparation for all rooms to be fully completed by 30/10/2026	

Regulation 5: Individual assessment and care plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: Respite residents and short-stay residents will have a comprehensive assessment and a holistic care plan commencing 31/08/26. PEEPs now contain sufficient detail. The MEG Audit Tool for developing and monitoring documentation in healthcare provision will be implemented. CNM 2s were trained w/c 10/08; this tool will be utilised for all Long Stay and Short Stay residents going forward.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: CNM2 will liaise with the activities coordinator daily to ensure activities align with individual care plans. Work is ongoing on the activities plan in conjunction with the Residents to determine their preferences, and we will ensure all information is displayed on the activities board. Activities of the day are also displayed on whiteboards in the residents' rooms. A new activities display board is currently being designed that will support all communication principles.	

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	30/09/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	14/07/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	30/09/2026

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	30/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/10/2026
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	16/07/2026
Regulation 34(1)(b)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall display a copy of the complaints procedure in a prominent position	Substantially Compliant	Yellow	31/10/2026

	in the designated centre, and where the provider has a website, on that website.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/10/2026
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/11/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident	Not Compliant	Orange	10/08/2026

	immediately before or on the person's admission to a designated centre.			
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.	Not Compliant	Orange	31/08/2026
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident is facilitated to communicate freely and in particular have access to radio, television, newspapers, internet and other media.	Substantially Compliant	Yellow	14/07/2026
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	30/09/2026