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:	Nephin Nursing Home
Name of provider:	Willoway Nursing Home Limited
Address of centre:	132 - 134 Navan Road, Cabra, Dublin 7
Type of inspection:	Unannounced
Date of inspection:	21 October 2025
Centre ID:	OSV-0005880
Fieldwork ID:	MON-0046679

About the designated centre

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

Nephin House is a purpose built facility and has a combination of single and shared accommodation over three floors. The centre can accommodate 61 residents, both male and female over the age of 18 years. There is an enclosed garden area located to the rear of the building which is accessible from the large dining room. Nephin House is situated on the busy Navan Road, and a variety of bus routes stop close by. Prior to admission to Nephin House, the resident is fully assessed by the director of nursing. A range of activities are provided which encourage residents to keep mobile and take an interest in life. Outings to the nearby community parks can be arranged. Full time nursing care is provided, for residents with needs that range from mild dependency to full dependency.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 21 October 2025	07:35hrs to 17:25hrs	Niamh Moore	Lead
Tuesday 21 October 2025	07:35hrs to 17:25hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

This inspection took place in Nephin Nursing Home, in Cabra Dublin 7. Most of the residents spoken with told inspectors they were happy with the care provided and that they were well looked after by the team of staff working there. 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. Six visitors spoken with reported that management were very visible, supportive and acted on any concerns that they raised. However, one recurrent area of feedback provided to inspectors was in relation to insufficient staffing levels.

Inspectors arrived to the centre at 07:35am and following a brief discussion with staff on duty, completed a walk around of the premises. The designated centre is registered for 61 residents with 54 residents on the day of the inspection. The premises is set out across four floors which were accessible by stairs and lift. Residents' bedroom accommodation is located on three floors, the ground, first and second floors. Each floor had combined day and dining rooms. The basement floor contained ancillary services such as the laundry, kitchen, staff changing facilities, staff break area, in addition to the treatment room, oratory, visitors room and hairdressers room. There was access to the garden from the ground floor which residents could freely enter. Following this walk around, inspectors met with two members of the management team including the person in charge to complete an introductory meeting.

The centre itself was laid out to meet the needs of the residents however, some resident's spoken with outlined that the additional communal areas in the basement, including the visitor's room and the oratory, were not used very much as they were so far away from the communal areas. In addition, inspectors found there were areas of the centre that required action to ensure it was cleaned to an acceptable level. When this was brought to the attention of the management it was addressed promptly.

The centre provides accommodation for 61 residents in 55 single and three-twin bedrooms. Since the last inspection, one twin-bedroom had been reduced to single occupancy, however inspectors saw that this resident's bedroom had inappropriate storage located inside which did not provide a homely environment for this resident. Overall, resident's bedrooms were of a sufficient size and layout, and many residents and their families had personalised their bedroom spaces with their individual belongings such as flowers, plants and photos. One twin bedroom, which was not in use on the day of the inspection was due to be reconfigured and there were plans in place for this. Residents had access to en-suites or shared bathrooms.

There was an activity schedule which listed activities for the week and overall residents were complimentary on the activity provision provided. However, during

the morning of this inspection activity staff were busy assisting with activities such as hairdressing. Inspectors found that during this time, there was little engagement other than task based activities for residents. The Health Service Executive were on site on the day of the inspection, offering residents the flu and COVID-19 vaccinations. Many residents were seen to be supported to avail of this programme.

Overall, residents said they were content and they appreciated the care they received by staff who were kind and caring, with comments such as "staff are very good" and "staff are lovely". Residents informed inspectors that they felt safe within the centre. However, inspectors observed occasions where there was insufficient supervision of communal areas, residents had to wait for staff assistance and residents were not supported in line with their preferences. Inspectors observed this was also raised in a residents' meeting in September 2025. This feedback was also received by visitors spoken with on the day, with one noting that the turn-over of staff was high and that agency staff did not know the residents, reporting that this mostly occurred at weekends. Another visitor praised the staff and recognised how hard they work but said "there were not enough of them".

Inspectors observed the breakfast and lunch-time meals being served on the day of the inspection. Residents were provided with a choice at mealtimes including an option for hot food at breakfast time. Inspectors observed staff supporting residents in a patient and kind manner, and all residents spoken with were complimentary about the food, with comments such as "I am very happy with the food" and "I enjoyed every second of my chicken". Inspectors observed that the ground floor day/dining room had sufficient dining room tables, while the day/dining room on the first and second floor had some dining room tables, in addition to armchairs and tray tables. Inspectors observed that most residents had their meals while seated in an armchair and using a bed side table, while the dining room tables were not fully utilised. However, all residents spoken with said it was their preference to not sit at the dining tables.

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

Capacity and capability

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). On this inspection, the inspectors also followed up on the compliance plan from the last inspection in November 2024 and both solicited and unsolicited information, received since then. Inspectors found that overall the regulatory compliance within the centre had declined, particularly in the areas of

staffing levels, supervision of staff and management oversight. Findings under the theme of Quality and Safety, are further discussed within this report.

Willoway Nursing Home Limited is the registered provider of Nephin Nursing Home. The management team was established and included the provider representative, a regional operations manager and the person in charge. The designated centre is part of the Grace HealthCare group and as a result, other management supports were available from this group such as Human Resources and Quality and Compliance. The person in charge was supported by an assistant director of nursing, nurses, healthcare, activity staff, housekeeping, catering, maintenance and administration.

Inspectors reviewed the data on the turnover of staff from January 2025 to the date of this inspection. A total of 12 staff left within this time, eight of which were healthcare assistants. Inspectors were told that on the day of the inspection there were five healthcare assistant vacancies which were in the recruitment stages, and being covered by temporary staff in the interim. The registered provider was also in the final stages of recruiting additional nursing staff to allow for three nurses on duty day and night, ensuring sufficient nursing cover to each floor.

Inspectors found that from a review of the rosters, observations and feedback received from residents and visitors during the inspection, there was not always sufficient staff to meet the needs of all of the residents living in the nursing home, as evidenced under Regulation 15: Staffing.

A review of training records indicated that all staff were up to date with mandatory training. However, further training was required, including on infection control to ensure staff were knowledgeable and competent in these areas. There was a process of formal supervision through staff induction records and annual appraisals. However, the arrangements for clinical supervision required review. This is further discussed under Regulation 16: Training and staff development.

Inspectors reviewed the electronic record of the directory of residents. Action was necessary to ensure the directory of residents was up-to-date and contained all information as required under Schedule 3 of the regulations.

The registered provider had a current certificate of insurance which specified that cover was in place against injury to residents.

The registered provider had completed an annual review for the year 2024 of the quality and safety of care delivered to residents to ensure the care was delivered in accordance with the National Standards. There was evidence of consultation with residents and families and a satisfaction survey was completed in November – December 2024. There was an improvement plan identified for 2025 with actions such as training on falls prevention and reviewing and auditing the dining experience.

While there was evidence of some good management systems in place, and many residents, visitors and staff spoke about good support from the management team, further oversight was required to ensure there was evidence of these oversight

systems identifying all areas for improvement, and progression of all required improvements. There were particular weaknesses identified in sufficient staffing levels which affected care provision and infection prevention and control governance, environment and equipment management. This is further discussed under Regulation 23: Governance and Management.

There was an accessible complaints procedure in place. Inspectors saw evidence where residents were supported to understand the process to make complaints through residents' meetings. There were three open complaints on the day of the inspection. Inspectors were aware that some of these complaints remained open outside of the complaints timeframes set out in the registered provider's policy. However, in a sample reviewed, evidence was seen that investigations were active and communication with complainants was ongoing. Family meetings were arranged to ensure the complainant was informed of the outcome of the investigation and any improvements recommended. However, the complaints procedure had not been fully adhered to in the management of one written complaint.

Regulation 15: Staffing

The registered provider had not ensured that there was a sufficient number and skill mix of staff available within the designated centre to meet the assessed needs of the 54 residents in accordance with Regulation 5, and the size and layout of the designated centre. For example:

- 48% 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 28% were assessed as being high dependency. Some residents spoken with told inspectors that at times staff were slow to respond to their needs. This was also seen recorded in residents' meeting minutes, complaints and from feedback of visitors. This was validated by inspectors' observations on the day of the inspection.
- Some staff spoken with told inspectors that there was not enough time to complete all assigned duties, especially during busy times such as during morning care delivery. Inspectors saw documented evidence where staff were providing bed baths to residents while their care plans outlined residents' preference for showers. In addition, inspectors also observed gaps in the provision of continence management. Inspectors were told this was due to time constraints.
- There was insufficient staff to allow for appropriate supervision of day rooms. For example, staff nurses were the only staff present in these areas while they were busy with other duties such as medicine administration. During this time, inspectors observed that one resident was waiting over 20 minutes for a cup of tea and there was an incident of peer-to-peer verbal aggression.
- Inspectors saw occasions where planned and unplanned leave for staff was not always covered. For example, on the day of the inspection leave was not covered for administrative staff, this meant that managers were supporting

the reception area and therefore reduced their time for staff supervision and oversight. In addition, one night shift was not appropriately covered as short notice cover was not provided. Inspectors saw that on the morning of the inspection, a night time staff member stayed on duty after their rostered hours had finished, to complete all of their assigned tasks.This practice required review.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had committed to providing 'Communication training for overseas staff' by September 2025, in a provider assurance report to the Chief Inspector, however at the time of this inspection, this training had not commenced.

Staff supervision required strengthening:

- Practices observed demonstrated that additional infection prevention and control training and supervision was required as outlined in Regulation 27: Infection control.
- There was ineffective supervision of staff to ensure that care interventions particularly relating to personal care provided to residents were based on assessments and care plans.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents did not meet the criteria as set out within Schedule 3 of the regulations. For example:

- The marital status of each resident was not recorded in a sample of nine records reviewed.
- The address of the resident's next of kin was not recorded in a sample of 31 records reviewed.
- The telephone number of the resident's next of kin was not recorded in a sample of 20 records reviewed.
- The address of the resident's general practitioner (GP) was not recorded in a sample of 22 records reviewed.
- The telephone number of the resident's GP was not recorded for any resident.
- The date the resident was temporarily transferred to another designated centre of hospital including the name was not recorded for one resident.

- The cause of death was not recorded for two records reviewed.

Judgment: Not compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that met the regulatory requirements.

Judgment: 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 household coordinator was working part-time and was also covering housekeeping hours, which was not in line with the full-time hours outlined within the statement of purpose dated August 2025.

The inspectors found that the management and quality assurance systems that would ensure that the service delivered to residents was safe and effectively monitored remained inadequate in a number of areas. Consequently, most of the inspectors' findings on this inspection, some of which required immediate action, had not been identified by the provider through their own oversight and auditing processes. This was evidenced by:

- Management systems in place did not ensure that the cleaning procedures in the centre were completed to the recommended standards to protect residents from infection.
- The provider had not nominated a staff member, with the required training, to the role of infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre.
- The oversight systems in place had not ensured that staff working within the designated centre were aware of where the additional clinical supplies were stored.
- There was a lack of oversight of care plans, inspectors identified that accurate information was not recorded in resident care plans to effectively guide and direct the care residents with suspected infections. This is further outlined under Regulation 5: Individual Assessment and Care Plan.
- There was poor oversight of medicines. For example, there were gaps in the temperature recording in the treatment room, and unsafe storage of medicines seen during this inspection.

- Despite feedback from families that staffing was a huge concern raised and discussed in Clinical Governance Meetings of September 2025, staffing had not been reviewed in line with dependency levels of residents.
- The registered provider had not ensured that commitments provided to the Chief Inspector through a provider assurance report had been fully actioned.

The registered provider did not fully facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. For example, staff and residents' meetings were completed together. This limited staff being able to provide open feedback to management.

Judgment: Not compliant

Regulation 34: Complaints procedure

Notwithstanding the overall good management of complaints seen, in one record reviewed, while the complainant did receive a written response informing them whether or not their complaint had been upheld, the reasons for that decision, and any improvements recommended, the details of the review process had not been issued.

Judgment: Substantially compliant

Quality and safety

Overall residents spoke positively about the care they received from the management and staff within Nephin Nursing Home. Inspectors observed that staff treated residents with kindness and respect. However, improvements were required in some areas for the quality and safety of the service, including that of care planning, the premises, infection control and medicines.

Residents had access to general practitioners (GPs), allied health professionals, specialist medical and nursing services including psychiatry of older age and community palliative care specialists as necessary. There was a low level of prophylactic antibiotic use within the centre, which is good practice. There was a low incidence of pressure ulcers in the centre which showed a good assessment of resident's needs. However, inspectors observed that the quality of care plans was inconsistent. For example, residents that were colonised with an infection did not have a plan to guide their care needs. In addition, some care plans were not reviewed within the last four months, and some were not sufficiently detailed to

guide care. This is discussed under Regulation 5: Individual assessment and care plan.

There was no restriction on visiting. Inspectors observed that visitors were coming and going through-out the day.

Overall the centre was well-maintained. However, some areas did not conform with the matters of Schedule 6 including the ventilation, and this is discussed under Regulation 17: Premises.

The findings of the inspection was that the provider did not comply with Regulation 27 and the National Standards for infection prevention and control in community services (2018). This is further discussed under Regulation 27: Infection Control.

Inspectors found that overall medicines and pharmaceutical services were in line with the regulations. For example, inspectors observed good practices in how the medicine was administered to the residents. However, medicine storage was unsafe and required review. This is further discussed under Regulation 29: Medicines and pharmaceutical services.

Regulation 17: Premises

Some areas of the centre required review to be fully compliant with Schedule 6 requirements. For example:

- The ventilation was not suitable for staff working in the laundry room. The room had no ventilation and was very hot, this meant that staff were using a stopper to leave a fire door open to circulate air.
- A resident's room was used as a storage area for equipment, this equipment was used to care for other residents. For example, inspectors observed a hoist, a wheelchair and a zimmer frame belonging to other residents stored within this bedroom during the inspection.

Judgment: Substantially compliant

Regulation 27: Infection control

Infection prevention and control (IPC) and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control. For example:

The registered provider did not ensure that IPC procedures in relation to environmental hygiene and practices were consistent with the standards published by the authority are in place and are implemented by staff. This was evidenced by:

- Areas of the centre and residents' equipment were visibly unclean and required urgent attention.
- Deep cleaning records were not consistent with the findings on the day of the inspection.
- Staff were not aware of the residents that were colonised with an multi-drug resistant infection as there was no reference made in the care-plans, nursing handover or any other methods of communication that is used. This increased the risk of infection spread should the need arise for extra precautions or antibiotic choice.
- The sharps bins at the nurses stations were open and not signed and one was filled past the overfill line. This increased the risk of a sharps injury for staff and reduced traceability of clinical waste.
- The management of soiled linen was not in line with the centres own IPC policy. For example, linen skips were not brought to the bedside to dispose of soiled linen. Some of the soiled linen in red bags were not placed in an alginate bag. This increased the risk of infection spreading to laundry staff.
- Hand hygiene facilities were not in line with best practice guidelines. For example, all the hand wash sinks in the centre did not meet the specifications of a clinical hand wash basin. The inspectors acknowledge that all were in good working order, some of the sinks in the hallways were difficult to clean due to heavy limescale. The placement of alcohol gel dispensers required a review . For example, the nearest dispenser to bedroom four was 20 feet away.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors observed prescribed medications stored in an unlocked cupboard at the nurse’s stations located within communal areas that residents and visitors could have access to. This was unsafe practice and posed a health and safety risk.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed residents' care documentation and found that nursing progress notes, assessment and care planning required improvement to ensure each

resident's health and social care needs were identified and were accurately detailed to guide safe care. This was evidenced by:

- The residents that were colonised with an infection did not have a care plan to guide the care. This was of particular importance for agency staff to read who did not know the residents.
- Two medicine care plans and two personal care plans had not been reviewed at intervals within the last four months.
- A resident's personal care plan reflected historical information such as the management of a pressure sore which was no longer present.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP) of their choice.

Residents also had access to a range of health and social care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of later life, and palliative care.

Judgment: Compliant

Regulation 11: Visits

There was suitable communal facilities and private areas available for residents to receive visitors. Visitors told inspectors that they were happy with the visiting arrangements in place.

Judgment: 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 19: Directory of residents	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 11: Visits	Compliant

Compliance Plan for Nephin Nursing Home OSV-0005880

Inspection ID: MON-0046679

Date of inspection: 21/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to address the concerns raised by the Inspectors in the inspection report, the Registered Provider has committed to the following actions: · Appropriate staffing and skill mix based on the dependency and to meet the needs of all residents in the Centre in line with the statement of purpose will be conducted on a monthly basis. · A continuous recruitment process is in place by Group HR and an update is given on a weekly basis to ensure the information of the new starters are communicated to the management team. · The Rosters are reviewed by local management on a weekly basis, with further review and oversight by the Regional Operations Manager to ensure the effectiveness of the rostering. Additionally, the allocation of staff within the Centre will continue to be reviewed on a daily basis, going forward. · Increased Supervision and monitoring by the Director of Nursing and Assistant Director of nursing and Household Co-ordinator to ensure that care practices align with regulatory standards and that any areas of concern are identified and addressed promptly. · An absence management policy will be updated and communicated within the home.	
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 registered provider assures the chief inspector that: · All nurses in the centre have completed the appropriate communication training programme to support overseas staff in clinical and social care communication. · Refresher IPC training will be completed by all staff, with emphasis on hand hygiene, PPE use, cleaning schedules, and contamination risk. · There is enhanced supervision by the management team and spot checks focusing specifically on IPC practices. · The management is focused on implementing corrective actions based on audit findings and provide additional coaching where non-compliance is identified. (Monthly IPC audits to ensure good practices) · Reinforce staff education on person-centred care, ensuring staff understand how to deliver care consistent with each resident's assessed needs. · Carry out direct observations/spot checks of personal care practices, record of care provided and provide immediate feedback to staff. · Audit care plans for accuracy, relevance, and evidence of updates following changes in residents' conditions.	
Regulation 19: Directory of residents	Not Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Registered Provider assures the Chief Inspector that: · A full Review of the Directory of Residents in the centre will be carried out to identify inaccuracies, gaps and sections that require updating. · The Directory includes all mandatory Schedule 3 details for each resident. · A consistent process will be implemented for maintaining the Directory and complete monthly audits of the Directory to ensure accuracy, completeness, and timely completion of entries.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The Registered Provider assures that: · A review of dependency has been completed and the centre. Staffing has been reviewed to ensure adequate numbers and skill mix to cater to the needs of the residents based on their dependency levels. · A continuous recruitment process is in place for the centre to ensure the recruitment, onboarding and induction is completed in a timely manner. · The Household coordinator is rostered in line with the statement of purpose to ensure effective delivery of care and to carry out assigned duties. · A review of the daily cleaning schedule has been completed, and a daily review is in place. · Daily checklists for housekeeping staff to verify completion of all cleaning tasks (public areas, residents' rooms, high-touch surfaces). · Monthly IPC audits will be completed to ensure adherences to IPC practices until consistency is maintained. · 1 Clinical nurse manager and 1 senior nurse have been identified infection prevention and control link practitioner to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. · Staff were re-educated on the location of the storage of the continence wear supplies. In addition staff are delegated to ensure stock is replenished after each shift. · An immediate review of all residents' care plans has been completed, with priority given to those with suspected or active infections. · An immediate review of the medication storage has been completed in accordance with safe storage requirements, ie: locked presses, controlled drug cabinets, appropriate room temperatures. · Regular staff meetings will be facilitated and encouraged to provide open feedback.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: · A full review of the complaints has been undertaken to ensure clear documentation, action plan discussed and improvements recommended is recorded under each written complaint.	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: · A review of the ventilation will take place by the registered provider. · A review of storage will be completed, and all inappropriate storage will be removed.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control: · An IPC link nurse has been identified in the home · The Link Nurse attends the Group IPC committee meetings. · The Link Nurse will complete audits with oversight of the local management team. · A review of resident equipment has been completed and cleaning schedules will be set. · A review of the deep cleaning schedules has been completed and a new schedule is in place. · Staff are made aware of any infections and what precautions are required at daily handover in the centre. · A review of antimicrobials use will continue on a quarterly basis. · Nurses have been re-educated on the use of sharp bins · A review of handwashing sinks will be completed, and installation of new sinks will be completed.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: · A nurses meeting was completed to communicate the importance of ensuring all cabinets where medications are stored and safely locked and kept secure at all times. · All nurses have been re-educated on the medication management policy. · Spot checks are carried out to ensure staff demonstrate proper medication storage practices. · Medication management competency assessment will be completed for all nurses.

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:

· Ongoing Review and updating care plans regularly to ensure they accurately reflect residents' needs, preferences, and risk assessments, and are used consistently by all staff.

· Care plans will be reviewed on a 3 monthly basis to ensure health and social care needs are included and detailed to ensure provision of safe care.

· Resident colonised with an infection have their careplans updated and this is reminded to all staff daily in handovers.

· A care plan audit was carried out, and all sections of the care plans have been updated, including the medicine sections.

· A 3 monthly care plan review is in place to ensure care plans are reviewed consistently, assessments are reviewed and updated to ensure the information is accurate.

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	31/03/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	28/02/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Substantially Compliant	Yellow	31/03/2026

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Not Compliant	Orange	12/12/2025
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.	Substantially Compliant	Yellow	31/03/2026
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	31/03/2026
Regulation 23(2)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	13/01/2026
Regulation 27(a)	The registered provider shall	Not Compliant	Orange	31/01/2026

	ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	11/12/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	22/10/2025
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	31/03/2026

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	31/01/2026