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:	St Camillus Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Unannounced
Date of inspection:	16 June 2026
Centre ID:	OSV-0000640
Fieldwork ID:	MON-0050704

About the designated centre

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

The designated centre of St Camillus' Community Hospital is located on the main campus of the hospital in Limerick city. The centre is operated by the Health Service Executive (HSE) and is registered to accommodate a maximum of 16 residents. Information provided in the statement of purpose for the centre describes care for people over 18 years of age across the range of abilities from low to maximum needs in relation to advanced age, vascular and neuro-injury, dementia and physical or psychiatric chronic illness. Care planning processes are in accordance with assessments using an appropriate range of validated assessment tools and in consultation with residents. Arrangements are in place to provide residents with access to activities and there is a variety of communal day spaces provided including a large activity area on the first floor. Visiting arrangements are in place and residents are provided with information about health and safety, how to make a complaint and access to advocacy services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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 16 June 2026	10:00hrs to 17:20hrs	Rachel Seoighthe	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out over one day. Residents who spoke with the inspector about their experience of living in the centre said it was a good place to live, and staff were described as being 'very good' and 'very nice'.

Located on the main campus of St Camillus Hospital, in Limerick city, the designated centre is registered to provide care for 16 residents. Resident private and communal accommodation is located on the first floor of the centre, in an area known as the Shannon unit. Access to the unit is by stairs, or by passenger lift via another designated centre which is located on the same site. There were 13 residents living the centre on the day of the inspection.

As identified on previous inspections, there were some areas of the centre that were in a poor state of repair. However, the development of a new 25 bedded unit on the same campus, was near completion, with residents currently accommodated in the Shannon Unit expected to transition to the new purpose-built accommodation on completion of works.

On arrival to the centre, the inspector observed that they could access resident private accommodation areas immediately, without the knowledge of staff or management, as an entrance door leading into the unit was not secured by any means. The risk of unauthorised access to the centre was discussed with the management team.

Following an introductory meeting, the inspector spent time walking through the centre, giving an opportunity to meet with residents and staff. In the morning, residents were observed to be up and about. The atmosphere in the centre was calm and relaxed. Some residents were observed spending time in the main communal sitting room, and other residents were receiving assistance with their personal care needs.

Resident bedroom accommodation was laid out in single and shared bedrooms, some with ensuite facilities. Many resident bedrooms were seen to be personalised with items of significance including pictures and soft furnishings. Televisions and call bells were provided in all resident bedrooms. One resident told the inspector that they enjoyed relaxing in their bedroom as it was 'very cosy'.

The inspector noted that additional furnishings had been provided in resident bedrooms, and work was ongoing to cover exposed pipework in some areas of the centre. The care environment was generally clean, however, some floor coverings, in assisted bathrooms and resident bedrooms, were not amenable to cleaning, as they were worn and damaged. The inspector observed that there was a lack of

suitable storage for resident mobility equipment, which was stored in a resident communal sitting room during the inspection.

On the walk though the centre, a number of fire safety risks were observed. There were gaps visible under resident bedroom doors, and several cross corridor fire doors did not close fully when released. A fire door leading into the activity centre was visibly damaged, and did not close to form an effective seal. A kitchen in the activity centre was observed to be cluttered with equipment and supplies. There was a large gap visible under the kitchen door, which could potentially impact the containment of smoke, fire and fumes, in the event of a fire emergency in this area.

The inspector observed that some residents spent long periods of time in the main sitting room, where the television was playing. A staff member was present at all times, however, limited meaningful activities were provided in the sitting room. In the morning, a walking club activity was scheduled for one hour. A small number of residents were observed mobilising throughout the centre, accompanied by a member of staff. However, the inspector noted that there were some residents who were unable to participate in this activity. In the afternoon, residents were supported to attend a game of bingo in another designated centre, however, an alternative activity was not provided for several residents who remained in the Shannon Unit.

The inspector noted that the provider had decorated the resident dining area since the previous inspection, to enhance the environment for residents. The feedback from residents in relation to the quality of food was positive, and the inspector was informed by one resident that the 'soup is always lovely'.

Visitors were observed attending the centre throughout the day of the inspection. Residents met with their loved ones in their bedrooms or communal rooms.

The next two sections of the report detail the findings with regard to the capacity and management of the centre, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced inspection to monitor the registered provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and to review the actions committed to by the provider following previous inspections. This inspection found that there was improved access to healthcare services, and the system in place to manage resident personal possessions was robust. However, residents' rights, contracts for the provision of care services, the complaints procedure, and governance and management were not not fully aligned with the requirements of the regulations. Furthermore, the registered provider failed to address non-compliances identified on

previous inspections, in relation to Regulation 28: Fire precautions, which posed a potential risk to the safety and wellbeing of residents living in the centre.

The previous inspection in March 2025, identified risks to effective fire containment in the centre. In response to this finding, an assessment of all of the fire doors in the centre had been commissioned by the provider. A procurement process, had been undertaken and a programme of remedial works was in progress, however this inspection found works to address deficits to multiple fire doors, which had been identified from the completed fire door assessment, had not been completed. Following the inspection, the provider was required to submit an urgent compliance plan to the Office of the Chief Inspector to ensure that all fire doors will perform as required, to ensure the containment of the spread of fire, smoke and combustion flames, in the event of a fire safety emergency in the centre.

The urgent compliance plan submitted by the provider was accepted by the Chief Inspector.

The Health Service Executive (HSE) is the registered provider of St Camillus Community Hospital. A general manager, and a director of nursing of older persons services provided senior clinical and operational oversight for St Camillus Community Hospital. The centre was one of two designated centres for older persons, located on the site of a large hospital campus. The provider was engaging with the Chief Inspector regarding the appointment of a new person in charge at the time of this inspection. Locally, the person in charge was supported by an assistant director of nursing (ADON), and a clinical nurse manager (CNM). A team of registered nurses, health care assistants, multi-task attendants, clerical staff and maintenance personnel, made up the staffing compliment.

This inspection found that care staffing resources had increased since the previous inspection, however, they were not fully aligned with the statement of purpose. There were vacancies for one nurse, two multi-task attendants and one healthcare assistant. The provider had begun recruitment processes to fill each post. On the day of inspection, there were sufficient nursing and care staff on duty to meet the needs of the 13 residents living in the centre. Records demonstrated that there was a registered nurse on duty at all times, to oversee the clinical needs of residents. Daily staffing levels were monitored by the person in charge, and appropriate staffing levels were maintained through roster management and use of agency staff, where required.

Records demonstrated that staff had access to a varied training programme and education, appropriate to their role. This included infection prevention and control training, safeguarding vulnerable persons, fire safety and patient moving and manual handling.

There were management monitoring systems which included a programme of clinical and environmental audits. Regular meetings took place with staff and management in relation to the operation of the service. A paper-based record of all accidents, incidents and complaints involving residents was maintained. The provider had systems in place to analyse incidents, and to identify areas where

practice could be improved. Incidents were appropriately notified to the Chief Inspector of Social Services, within the required time-frame.

There was a procedure in place for the management of complaints. A sample of complaints reviewed by the inspector found that, although complaints were resolved and concluded, the documentation of complaint investigations did not align with the requirements of the regulations.

A review of a sample of the contract for the provision of services in place for residents found that the terms of the agreement did not include the occupancy level of the bedroom provided to residents who attended the centre on a short term basis. This is discussed under Regulation 24: Contracts for the provision of care.

A sample of staff files reviewed contained all of the required information as set out under Schedule 2 of the regulations.

Regulation 15: Staffing

There were sufficient numbers of staff available with an appropriate skill mix having regard for the needs of the residents and the layout of the centre. A review of the rosters confirmed that there was a registered nurse on duty at all times in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training records demonstrated that staff were facilitated and supported to attend training in fire safety, moving and handling practices, and safeguarding vulnerable persons.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that the nursing, care and multi-task attendant staffing resources were sufficient to provide care and services, in line with the centres' statement of purpose.

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

- Deficits in relation to the performance of fire doors were identified on repeated inspections, and in a fire risk assessment, commissioned by the provider. However, this risk had not been addressed at the time of inspection.
- Risks regarding unauthorised access to the centre had not been identified by the providers management systems.
- There was inadequate oversight of residents rights', complaints management, and contracts for the provision of care services.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

A sample of contracts for the provision of care was reviewed by the inspector. Contracts viewed did not align fully with the requirements of the regulation. For example:

- The resident bedroom number and occupancy of the bedroom were not recorded in contracts for residents who were admitted to the centre on a short-term basis.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifiable incidents, as detailed under Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time-frame.

Judgment: Compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that although complaints were addressed and resolved, a sample of complaints records viewed by the inspector found that the documentation of complaint investigations did not align with the centre's own policy, and the requirements of the regulations.

Judgment: Substantially compliant

Quality and safety

The findings on the day of inspection were that the provider was delivering satisfactory care to residents, in line with their assessed needs. Residents had good access to health care services, including a medical officer, dietitian, and physiotherapist. However, residents' rights, premises and fire precautions did not align fully with the requirements of the regulations.

In response to the finding of a previous inspection in March 2025, an assessment of all of the fire doors in the centre had been commissioned by the provider. A procurement process had been undertaken and a programme of remedial works was underway, however this inspection found works to address deficits to multiple fire doors, which had been identified from the completed fire door assessment, had not been completed.

In the absence of satisfactory assurances regarding fire precautions in the centre, the provider was required to submit an urgent compliance plan by 23rd June 2026. This plan was accepted by the Chief Inspector.

The designated centre had a fire safety system in place, including fire-fighting equipment and a fire detection and alarm system. However, the inadequate maintenance of some fire doors posed a potential risk to fire and smoke containment, in the event of a fire emergency. Several cross corridor fire doors did not close fully to form an effective seal when the fire doors were released, closure devices some on fire doors did not function, and gaps were visible under a number of resident bedroom doors. This is a repeated finding. Poor fire safety management was observed where the provider failed to take adequate precautions to prevent a potential fire risk in a kitchen area. This is detailed under Regulation 28: Fire precautions.

Residents' bedroom accommodation was individually personalised. A programme of maintenance work was ongoing. However, the inspector identified some areas of the premises which were in a state of disrepair, such as floor surfaces. Furthermore, the organisation of storage was not adequate to meet residents needs. This is discussed further under Regulation 17; Premises.

While there was a programme of activities in place, some residents were unable to participate in the activities scheduled, and there were no alternative arrangements made. This observation was supported by a review of resident activity records which demonstrated that television was recorded as the only daily activity for some residents. The provider had not ensured that there were consistent opportunities for

all residents to participate in meaningful activities on a daily basis, in accordance with their interests and capacities.

The centre had a paper-based resident care record system. Pre-admission assessments were undertaken by the person in charge, to ensure that the centre could provide appropriate care and services to the resident upon admission. A range of validated nursing tools were in use to identify residents' care needs. The inspector viewed a sample of files of residents with a range of needs and found that residents' individual assessments were completed in a timely manner, and used to inform person-centred care plans.

A review of residents' care records confirmed that they had regular access to a medical officer. Clinical risks, such as infection, wounds and falls were monitored by the nursing team. There was a system in place to refer residents to allied health services such as occupational therapy, speech and language therapy, dietetics, and psychiatry of later life.

Regulation 17: Premises

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

- The décor in some parts of the centre was showing signs of wear and tear. Surfaces and finishes including wall paintwork, floor covering and wood finishes in some resident bedrooms could not be effectively cleaned.
- Floor covering in the kitchen was damaged.

There was insufficient storage space for resident equipment.

- Mobility equipment including wheelchairs and seating systems were being stored in a resident communal room, when not in use.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider failed to take adequate precautions against the risk of fire. For example:

- Surfaces in the kitchen in the activity centre, including the oven hob, were cluttered with equipment, paper and plastic supplies, and electrical items. This posed a potential fire risk.
- The kitchen in the activity centre was locked with a key, which was held by a member of staff. There were no spare keys located in close proximity to the

door. This may pose a delay in accessing this room, in the event of a fire emergency in the centre.

There were inadequate arrangements for the containment of fire in the centre. For example:

- Several cross corridor fire doors did not close fully to form an effective seal when the fire doors were released.
- The cross corridor fire door at the entrance to the activities centre, was visibly damaged, did not close, and had visible gaps at the top and bottom of the door.
- The closure device on a communal sitting room fire door did not function and the door did not close fully.
- There was a large gap under the kitchen door in the activity centre.
- Several resident bedroom doors had gaps at the bottom of the door and self-closing devices did not function on some resident bedrooms doors.

An urgent compliance plan was requested to provide assurances that the registered provider shall undertake works to ensure that all fire doors will perform as required, to ensure the containment of the spread of fire, smoke and combustion flames, in the event of a fire safety emergency in the centre.

The urgent compliance plan submitted by the provider was accepted.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Individual assessment and care planning documentation was available for each resident in the centre. Records showed that care plans contained detailed information, specific to the individual needs of the residents.

Judgment: Compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment. Residents also had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age, and palliative care.

Judgment: Compliant

Regulation 9: Residents' rights

The provider did not ensure that residents were provided with opportunities to participate in activities in accordance with their interests and capacities on a consistent basis. There were some residents who seen spending long periods of time in the communal sitting room, where the television was playing. While staff were present in the sitting room, they were not seen to be facilitating meaningful activities. This is a repeated finding.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Camillus Community Hospital OSV-0000640

Inspection ID: MON-0050704

Date of inspection: 16/06/2026

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The Registered Provider acknowledges the findings relating to governance systems, oversight arrangements, fire safety management, security of access, complaints management, residents' rights and contractual arrangements. A programme of corrective actions has been implemented and will continue to be monitored through local governance structures.

Actions Completed

• Coded keypad and intercom access controls were installed at the Shannon Ward rear entrance to prevent unauthorised access to resident accommodation.

• Contract of care templates have been amended to include bedroom number and occupancy details for all residents, including short-term admissions.

• A revised complaints management template has been introduced to ensure complaints show the investigation undertaken as part of the complaint resolution process.

Further Actions

• A revised governance dashboard has been implemented and includes fire safety, residents' rights, complaints management, contracts of care, environmental audits and quality improvement actions as standing agenda items.

• Monthly governance meetings will review regulatory compliance progress against all HIQA compliance actions, complaints, environmental audits, activity audits and fire safety actions. Progress will be monitored, actions tracked and escalated where required.

o Owner: Person in Charge

o Completion: Immediate and ongoing

• Quarterly provider assurance reviews will be undertaken to ensure sustained regulatory compliance and effectiveness of management systems.

o Owner: Director of Nursing Older Persons Services

o Completion: Commencing October 2026

• Audit findings, action plans and completion rates will be reviewed quarterly through the Older Persons Services governance structure to ensure oversight of risks, complaints, residents' rights and contractual compliance.

o Owner: Director of Nursing Older Persons Services
o Completion: Commencing October 2026
• Recruitment activity will continue to address outstanding vacancies through recruitment campaigns and agency conversion processes to ensure staffing resources remain aligned with the Statement of Purpose.
o Owner: Director of Nursing / HR Department
o Completion: Ongoing
Compliance Date: 31 October 2026

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
The Registered Provider has reviewed admission processes and contractual documentation to ensure compliance with regulatory requirements relating to bedroom allocation and occupancy information.
Actions Completed
• All contract templates have been updated to include resident bedroom number and occupancy arrangements.
• All residents admitted for short-term care are now issued with a contract of care containing bedroom allocation and occupancy details.
Further Actions
• An audit of all current contracts of care will be completed to verify compliance with Regulation 24 requirements.
• Owner: ADON
• Completion: 30 September 2026
• Admission documentation has been revised to include verification of bedroom allocation and occupancy details prior to admission.
• Owner: Clinical Nurse Manager
• Completion: Completed
• Quarterly audits of contracts of care will be incorporated into the governance audit schedule.
• Owner: ADON
• Completion: Commencing October 2026
Compliance Date: 30 September 2026

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Registered Provider acknowledges the inspector's findings relating to complaint investigation and recording processes and has strengthened local oversight arrangements to ensure all complaints are investigated, documented and concluded in line with regulatory requirements.
Actions Completed
• A revised complaint management template has been introduced.
• Staff have been advised regarding complaint reporting, investigation and documentation requirements.
Further Actions
• A full review of complaints identified during inspection will be completed to ensure each complaint has been appropriately investigated, documented and concluded in accordance with Regulation 34.
o Owner: Person in Charge
o Completion: 30 September 2026
• A retrospective audit of all complaints received during the previous 12 months will be completed to ensure investigation records contain evidence of findings, actions, communication with complainants and closure.
o Owner: ADON
o Completion: 31 October 2026
• The complaints register will be reviewed monthly through governance meetings to ensure complaints are investigated and concluded within required timeframes.
o Owner: Person in Charge
o Completion: Immediate and ongoing
• Training and guidance will be provided to staff on complaint recognition, investigation, documentation and resolution processes.
o Owner: ADON
o Completion: 31 October 2026
• Quarterly audits of complaint management practices will be completed and trends, learning and actions reviewed through governance structures.
o Owner: ADON
o Completion: October 2026 and quarterly thereafter
Compliance Date: 31 October 2026

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Registered Provider acknowledges that areas of the premises require improvement to fully meet the requirements of Schedule 6. Improvements are underway through an ongoing refurbishment and maintenance programme.

Actions Completed
• Mobility equipment and wheelchairs are no longer stored in communal resident areas.
• Existing environmental improvement works continue throughout the centre.
Further Actions
• Damaged flooring within identified resident bedrooms and kitchen areas will be replaced.
• Owner: Maintenance dept
• Completion: 31 January 2027
• A programme of repair and redecoration works will be completed in identified areas of wear and tear.
• Owner: Maintenance Dept
• Completion: 31 January 2027
• Additional storage solutions for wheelchairs, mobility aids and seating systems will be introduced.
• Owner: Person in Charge
• Completion: 30 September 2026
• Monthly environmental audits will be undertaken and reviewed through governance meetings.
• Owner: ADON
• Completion: Immediate and ongoing
Compliance Date: 31 December 2026

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider acknowledges the findings relating to fire-containment arrangements and fire-door performance within Shannon Ward. Interim fire-safety measures, enhanced monitoring arrangements and local governance oversight remain in place to mitigate risk pending completion of the approved programme of fire-door remediation works. The effectiveness of these controls will continue to be reviewed until the works are completed, certified and formally signed off.
The original completion date was not achieved as the procurement process required further progression before the commencement of works. Following completion of the tender process, the company initially identified as the successful tenderer subsequently withdrew from the project. Further contractual and procurement arrangements were therefore required to appoint an alternative contractor. HSE Estates actively progressed these arrangements and a new contractor was appointed on 5 October 2026. While this has resulted in a revised implementation timeline, interim fire-safety controls, enhanced monitoring arrangements and governance oversight have remained in place pending completion of the required works.
The revised programme provides for completion of the detailed site survey, risk assessments and method statements, and material approvals between 9 October and 23 October 2026. The required fire doors and associated ironmongery will be ordered

following approval, with manufacture and delivery scheduled for completion by 18 December 2026. Taking account of the planned Christmas shutdown period, installation will commence on 4 January 2027 and is scheduled for completion by 5 February 2027. Final inspections, certification, resolution of any outstanding snagging and formal sign-off will be completed by 12 February 2027.
Actions completed
• Combustible materials and inappropriate storage were removed from the kitchen and activity areas immediately following the inspection.
• Daily fire-safety monitoring and environmental fire-safety checks have been implemented.
• Enhanced monitoring of fire-containment measures remains in place pending completion of the remedial works.
• HSE Estates commissioned a comprehensive fire-door assessment and completed a tender process for the required upgrade, repair and replacement programme.
• Following the withdrawal of the initially successful tenderer, the required procurement and contractual arrangements were progressed and an alternative contractor was appointed on 5 October 2026.
Further actions
• Complete the detailed site survey, risk assessments and method statements, and material approval process.
Owner: Appointed Contractor/HSE Estates/HSE Maintenance
Completion date: 23 October 2026
• Order the required fire doors and associated ironmongery following approval of materials.
Owner: Appointed Contractor
Completion date: 23 October 2026
• Complete the manufacture and delivery of the required fire doors.
Owner: Supplier/Appointed Contractor
Completion date: 18 December 2026
• Complete all identified fire-door upgrades, repairs, replacements and associated compliance works.
Owner: Appointed Contractor/HSE Estates
Completion date: 5 February 2027
• Complete final inspections, certification, resolution of any outstanding snagging and formal sign-off of the completed works.
Owner: Appointed Contractor/HSE Estates
Completion date: 12 February 2027
• Continue daily inspection and monitoring of fire doors and other fire-containment measures until the works are completed and formally certified. Any deterioration or additional concern identified will be escalated promptly for review and action.
Owner: Clinical Nurse Manager/Nurse in Charge
Completion date: Daily and ongoing until final sign-off
• Continue monthly fire-safety review meetings involving HSE Estates, local management and relevant fire-safety personnel. Progress against each programme milestone will be recorded, monitored and escalated where required.
Owner: HSE Estates/Person in Charge
Completion date: Monthly until final sign-off
• Continue to monitor the outstanding works, programme dependencies and interim controls through the centre’s risk-management and governance structures.

Owner: Person in Charge/Director of Nursing
Completion date: Ongoing until final sign-off
The revised programme is dependent on the timely approval of risk assessments and method statements and materials, the anticipated manufacturing lead time, agreed access to occupied clinical areas and no significant additional fire-compartmentation defects being identified during the installation works. These dependencies will be monitored through the HSE Estates programme and the centre's governance arrangements, with any delay or emerging risk escalated appropriately.
Revised compliance date: 12 February 2027

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Registered Provider acknowledges the findings relating to opportunities for residents to participate in meaningful activities consistent with their interests, preferences and capacities. Improvements have been implemented to strengthen activity provision and meaningful engagement for all residents.
Actions Completed
• A revised activity programme has been introduced to support a more person-centred and individualised approach to activity provision.
• Staff have been reminded of the requirement to facilitate meaningful engagement throughout the day.
Further Actions
• All residents' social care assessments and activity preferences will be reviewed and updated.
o Owner: Activities Coordinator / Nursing Team
o Completion: 30 September 2026
• Individualised one-to-one activity plans will be implemented for residents who are unable or unwilling to participate in group activities.
o Owner: Activities Coordinator
o Completion: 30 September 2026
• Weekly review of activity participation records will be undertaken to identify residents with low levels of engagement.
o Owner: Activities Coordinator
o Completion: Immediate and ongoing
• Residents identified as having limited participation will have an individual engagement plan developed and reviewed regularly in consultation with the resident and/or their representative.
o Owner: Nursing Team / Activities Coordinator
o Completion: Ongoing
• Monthly audits of activity participation and meaningful engagement will be undertaken.
o Owner: ADON
o Completion: October 2026 and ongoing

• Resident feedback regarding activities and meaningful occupation will be sought through resident meetings and satisfaction surveys and incorporated into service planning.
o Owner: Person in Charge
o Completion: Monthly
• Activity provision and resident participation data will be reviewed through governance meetings to ensure all residents consistently receive opportunities appropriate to their interests and capacities.
o Owner: ADON / Person in Charge
o Completion: Ongoing
Compliance Date: 30 September 2026

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2026
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.	Substantially Compliant	Yellow	31/10/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	31/10/2026

	consistent and effectively monitored.			
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	30/09/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	12/02/2027
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides	Substantially Compliant	Yellow	31/10/2026

	that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.			
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