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. Gladys Nursing Home
Name of provider:	Willoway Nursing Home Limited
Address of centre:	53 Lower Kimmage Road, Harold's Cross, Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	16 February 2026
Centre ID:	OSV-0000686
Fieldwork ID:	MON-0049587

About the designated centre

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

St. Glady's Nursing Home is located in a suburb of Dublin and close to local shops, bus routes and social amenities such as parks. It is a period building which has been developed to each side of the original building. It is registered to provide care for up to 47 residents. There are 21 single rooms, and 13 sharing rooms. Some of the bedrooms are en-suite and there are accessible bathrooms and toilets throughout the centre. The centre provides care of the elderly, but can also support residents under retirement age. The service is provided to residents with low, medium, high and maximum dependency. They focus on meeting residents needs in relation to care of the elderly, Alzheimer's, dementia or psychiatric needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	45

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 16 February 2026	08:15hrs to 15:00hrs	Laurena Guinan	Lead

What residents told us and what inspectors observed

Residents living in St Glady's Nursing Home told the inspector that they were happy and felt well-cared for, and the atmosphere on the day of the inspection was calm and relaxed. Residents described the centre as a 'lovely place to live' and 'great'. This was an unannounced inspection to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to inform the renewal of the centre's registration. The inspector also followed up on the compliance plan from the previous inspection, and statutory notifications submitted to the Chief Inspector since the last inspection in September 2025.

The centre was set in a period property that had been extended, and was spread over two floors. Access to the floors was via lifts and stairways. The reception area had a visitor sign-in book and information on complaints, safeguarding and fire safety. The ground floor of the original building contained dining and living spaces, as well as the kitchen, toilets and storage facilities, and the first floor housed residents' bedrooms and an office. The dining and living areas were seen to be clean and tidy, and both were well used on the day of inspection. There was an extension on each side of the building which housed residents bedrooms, bathrooms and communal facilities. The inspector saw that bedrooms were clean and tidy, with many personalised with residents' own belongings. Bedroom doors had a glass panel which had been covered with privacy screenings, but the inspector saw that part of the screening had come away on some doors, which gave passers-by a view into the residents' bedrooms. Bathrooms and communal rooms and corridors were also seen to be clean, but areas of worn flooring and chipped paintwork were observed. These will be discussed later in the report.

Lighting in the centre had been changed since the last inspection, and a new cleaning regime had been implemented, so the centre appeared bright and fresh. The corridors were all free of obstruction and communal areas were tidy and decorated with residents artwork and pictures. The centre had a number of storage rooms and some of these had boxes stored on the floor which did not ensure effective cleaning. This was brought to the attention of the person in charge and will be discussed later in the report. A sluice room on Wing B was seen to have basins on the draining board, with two urinals in one of the basins. There were no racks available to dry and store clean equipment. This did not support good infection control practices and was brought to the attention of the regional manager who said they would procure a drying rack to rectify the issue. Sluices and store rooms were appropriately secured. The treatment room was located in the main building and was kept locked during the day. The room was small, with limited space for movement, but was clean and tidy. The medicine trolleys were stored here and both were locked. The medicine fridge had daily temperature check records completed.

The inspector saw lunch and breakfast being served. Many residents chose to dine in their rooms for breakfast, and their breakfast was prepared individually and served hot. The dining room was used by many residents at lunch time, and a smaller number chose to eat in the living areas. The meal was well presented, and portions were of a good size. Residents spoken with said that the food was tasty and there was a good choice. One resident who said she did not have a good appetite that day was accommodated to have a different choice of food. There was adequate staff to assist residents, and the atmosphere was calm and social.

Residents had access to secure outdoor areas which were well-maintained and had an appropriately equipped smoking area. The inspector saw residents engaging in activities such as art, watching TV, and a relaxation session. Staff were seen to interact positively with residents, and encourage those of different abilities to participate. Residents who became distracted or chose to move around were assisted in a kind and respectful manner. The centre had recently converted a bedroom on each wing into communal rooms to provide additional space for residents. However, the inspector saw that there were items such as hoists, wheelchairs and tables stored in these rooms which did not make them fully accessible for residents or promote a homely environment. This will be discussed later in the report.

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 impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found this was a well-managed centre, with systems in place to support the provision of a quality service for residents. Notwithstanding this, gaps were seen in the of oversight of the premises and allocation of staff.

Willoway Nursing Home Limited is the registered provider for St Glady's Nursing Home. The company is part of the Grace Healthcare (Holdings) Ireland Limited. On inspection in September 2025, the centre was found to be operating without an appropriate person in charge. Subsequently, a cautionary meeting was held with the provider. Following this the vacancy was filled in October 2025, and the person had the qualifications and experience as required by the regulations. The person in charge worked full-time in the centre and was supported in their role by two clinical nurse managers. Staff nurses, healthcare assistants, activities coordinators, household, catering and maintenance staff made up the remainder of the staff team in the centre. The regional manager was also on-site at least twice monthly to support the governance of the centre, and was present on the day of this inspection.

The inspector reviewed a schedule of resident and staff meetings. These were held regularly, and had action plans in place to address issues identified. The action plans seen had all been completed. For example, issues with hot water supply raised at a meeting in January had been assigned to the maintenance manager, who had resolved it with the purchase of a new pump.

In the compliance plan from the last inspection, the registered provider had committed to improve the oversight of cleanliness, maintenance, care plans and storage in the centre. The person in charge had implemented spot checks to monitor cleaning and maintenance in the centre. Daily and deep cleaning checklists had also been introduced. The cleaning staff were familiar with the requirements of the checklists, and this was seen to have improved the cleanliness of many areas of the centre. The maintenance log was reviewed, and items that required attention were seen to be addressed in a timely fashion. There was a system of maintenance checks in place to ensure equipment such as fire doors and call bells were fully functional, and faults were identified and rectified promptly.

The person in charge conducted regular call bell audits, and delays were discussed with the staff on duty at the time. Care plan audits were also conducted, and where gaps were seen, the nurse responsible was consulted and advised. The audits had identified gaps in care plans and these were also the findings of the inspector during this inspection. The person in charge was actively working to remedy these. The oversight of storage was an outstanding issue and impacted on effective cleaning, and residents' access to and use of communal spaces.

The registered provider had also committed to updating the centre's policy on safeguarding to include the procedure for instances of confirmed abuse, and this had been completed.

The inspector reviewed the staff roster and saw that there was an adequate number and skill mix of staff. On a number of days over the weekend, however, there was no senior staff nurse on duty to act in a supervisory capacity, as committed to in the provider's compliance plan. There was also planned annual leave for an activities staff, with no staff assigned to cover this role on the roster. This was brought to the attention of the person in charge who said that they had secured staff to cover one of the days. This meant that there would be no activities staff on duty to provide activities to the residents for two days, despite there being a system in place with the Grace Healthcare Group to provide cover for absences.

There was an active recruitment campaign to prepare for impending resignations. Residents' meetings showed that residents had been consulted about new staff, with residents saying that they liked to see new faces. Residents spoken with said that staff were always available to assist them. They said they knew a lot of the staff and that the staff 'knew them well'. During the day, the inspector observed call bells being attended to promptly, and there was good supervision of residents in communal rooms.

The submission of notifications to the Chief Inspector was discussed with the person in charge. An incident had been correctly identified and dealt with by staff, but had

been escalated to the person in charge despite them being on annual leave at the time. This resulted in the late submission of the notification by three days. The person in charge acknowledged the error and had since addressed the issue with staff. They were made aware of the procedures to follow when reporting concerns, and the correct escalation pathways to follow to ensure timely submission of notifications.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had submitted an application to renew the registration of the designated centre within the correct time frame, and with the required information.

Judgment: Compliant

Regulation 15: Staffing

The staff and skill mix was appropriate to the number and needs of residents, with the exception of the allocation of staff to cover activities staff annual leave. This meant that there was a period of time where no staff were allocated to facilitate activities for the residents.

Judgment: Substantially compliant

Regulation 23: Governance and management

Inspectors found that the management systems in place generally ensured that the service provided was safe, appropriate, consistent and effectively monitored, however, the oversight systems in place to ensure compliance with the regulations was insufficient. This was evidenced by the following:

- Inappropriate storage practices in bathrooms, sluice and store rooms that did not support good infection control. These are repeat findings.
- While additional communal rooms had been provided, inappropriate storage practices in these rooms made it difficult for residents to access them independently, and did not make them suitable for use by residents.
- While cleanliness in the centre had improved, and some upgrades had taken place, areas of worn flooring and chipped paintwork did not ensure the premises conformed to Schedule 6 of the regulations. This is a repeat finding.

- There was a commitment on the compliance plan from the previous inspection to allocate a senior staff nurse to act in a supervisory capacity at weekends. The roster showed a number of weekend days where this had not been implemented. This did not ensure clear lines of accountability, and posed a risk that appropriate clinical leadership and decision-making support were not consistently available. For example: an incident had occurred when there was no senior personnel on duty. This incident was not notified to the Chief Inspector within the regulatory timeframe, as the staff on duty were not aware of their responsibility and there was no clear guidance provided to them on this matter.
- The oversight systems in place to ensure staff practices aligned to a human rights-based approach were insufficient. This was evident by the use of a shower list for residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had submitted notifications to the Chief Inspector within the required timeframe.

Judgment: Compliant

Quality and safety

Residents living in St Glady's Nursing Home were seen to receive care from a staff team who were familiar with, and attentive to, their needs, and the inspector saw residents being treated with kindness and respect. There was a schedule of maintenance in place for areas of wear and tear. However, storage remained an issue which had an impact on effective cleaning, as well as on residents access to and use of communal spaces, and there were gaps in the documentation of residents' care needs.

The inspector reviewed a sample of care plans and found that, while the care plans had been reviewed at regular intervals, they had not all been revised and therefore the quality and accuracy of the information recorded did not consistently reflect the residents' assessed needs. This will be further discussed under Regulation 5: Individual assessment and care plan. Nonetheless, staff who spoke with the inspector were knowledgeable about the residents' current needs. This was discussed with the person in charge and the regional manager, who said that care planning was regularly discussed at staff meetings, and staff had attended training

in the area. However, gaps continued to be observed in the auditing process and care planning was identified as an area of improvement that required review.

Residents had access to a comprehensive activities schedule, which included group and individual activities, and encouraged community involvement. Residents spoken with said they enjoyed the activities, especially bingo and music activities. There were regular residents' meetings which showed that residents were kept informed of changes such as a new laundry provider and pharmacy service. Residents' views were also considered, and a request for new residents to be introduced so they could be made welcome resulted in a new resident instigating the formation of a Bridge club. Minutes of a management meeting showed that a family had expressed concern about the provision of weekend activities. While residents spoken with did not express any dissatisfaction, allocation of weekend activities staff was not always assured, as discussed earlier in the report.

The registered provider took action to increase the communal space available for residents by de-registering two bedrooms and converting them to communal rooms. Residents were informed of the changes during residents' meetings. However, the inspector saw equipment being stored in these rooms, with hoists partially blocking the doorway of one room. This prevented residents from safely accessing the rooms and did not make them inviting or comfortable spaces for residents to spend time in. In the minutes of residents' meetings, the rooms were referred to as sensory rooms, however, they were not furnished with lighting or similar equipment to facilitate a sensory experience. The inspector was informed that there were plans to source the necessary equipment to meet the sensory needs of residents.

The inspector observed a folder at reception that contained a 'shower list' of residents' names, and days allocated for them to have a shower. One of the residents who spoke with the inspector said that they could choose when to have a shower, and the person in charge confirmed that residents were consulted about their shower preferences on a daily basis. The person in charge acknowledged that the use of a 'shower list' could make it difficult for staff to embrace a human rights-based approach to care, particularly for residents who had cognitive impairment.

Although improvements had been made in the cleanliness of the centre, many areas required refurbishment to ensure a safe and comfortable environment was provided. For example, worn flooring in bathrooms and chipped paintwork throughout the centre was not aesthetically pleasing, and did not support effective cleaning for infection prevention and control. The inspector spoke with the maintenance manager who provided a plan to replace the flooring in the bathrooms and communal rooms. Additional work such as replacing skirting boards, repair of the glass screen in the visitors' room, and painting was also scheduled. It was planned to have the works completed by the end of March 2026. Maintenance had consulted with management to ensure the refurbishment would be completed in stages to accommodate the needs of, and reduce the impact on, residents. There were no plans to provide additional storage in the centre in the short-term. The impact of the lack of storage on residents and regulatory compliance was discussed during the

feedback meeting and the management staff present agreed that it required further review.

Regulation 17: Premises

The premises did not fully conform to the matters set out in Schedule 6 as evidenced by:

- Lack of appropriate storage facilities resulted in items not stored correctly in store and sluice rooms, and inappropriate items stored in bathrooms and communal rooms. This did not support good infection control and impacted on the residents' ability to use communal rooms.
- While a plan of refurbishment had been developed, there were areas of the property that were not sufficiently maintained and did not support a safe and clean environment. For example:
    - Flooring in some of the shower rooms was damaged.
    - Chipped paint was observed on walls, doors and skirting boards throughout the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Not all care plans were updated and revised to reflect the residents' current care needs. For example:

- The level of modified diet for one resident was documented as both level six and level seven. It was stated that they had been referred to and seen by a dietician, but the care plan contained no details of the recommendations made on the consultation which followed.
- The use of a floor alarm had been changed to a bed alarm after reassessment of the resident's condition. However, the assessment had not been updated. While the change was documented in the care plan, and staff were aware of it, use of the floor mat was also still documented, making it difficult to ascertain the correct alarm to use.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Some elements of the premises and staff practices did not fully support a rights-based approach to care. This was evidenced by:

- While the registered provider had provided access to additional communal spaces, these areas were not accessible to residents due to the inappropriate storage in the spaces, and they were not set up as comfortable spaces for residents to use as they chose.
- The screening on some bedroom doors did not provide sufficient privacy for residents.
- The use of a shower list did not ensure that a human rights-based approach to care was being promoted in the centre.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. Gladys Nursing Home OSV-0000686

Inspection ID: MON-0049587

Date of inspection: 16/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: · The PIC and Regional Manager have reviewed the roster to ensure adequate staffing levels and skill mix to meet the care needs of the residents. · All annual leave for activity staff will be reviewed. When an activity staff goes on annual leave a staff member with the required skill set will be identified to cover the function of activities. The PIC and Regional Manager will have oversight of this. · A fortnight review of the roster will be completed by the PIC	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: · The person in charge shall ensure all storage areas facilitate effective infection control and that storage is compliant with health and safety standards. · An immediate audit of all storage areas, sluice rooms, and bathrooms was conducted by the Person in Charge (PIC) to identify inappropriate storage. · The person in charge will ensure communal spaces are fully accessible, clean, and safe for resident use. The person in charge/Clinical Nurse Manger/Senior nurse will be responsible for completing spot checks regularly to ensure staff adhere to safe practices. · All inappropriate items and clinical waste stored inappropriately has been removed immediately. · A review of the inventory/equipment list will be conducted to identify if excess equipment can be disposed of or moved to off-site storage to declutter areas.	

· All non-essential items and stored equipment will be removed from designated communal rooms immediately.
· A weekly checklist will be introduced to ensure communal areas remain clear and accessible.
· A review of the centre has been completed by the PIC, Regional Manager and Head of Facilities to identify worn flooring and where paintwork requires upgrading. An action plan which includes replacing worn flooring, paintwork and refurbishment of bathrooms, has been completed. Works have commenced and is ongoing.
· Recruitment of staff nurses has been completed since the inspection. Full complement of nurses are now in place.
· The staff nurse roster has been reviewed and a senior nurse is rostered every weekend to ensure appropriate clinical leadership and decision-making support is available.
· All senior nurses will be made aware of their roles and responsibility and clear lines of accountability as a senior nurse in charge at the weekend.
· Training on the incident management policy will be provided to all senior staff nurses to ensure they understand the legal requirement for notifications to the Chief Inspector within the required timeframes.

· An On call support is available for all senior nurses at the weekend via PIC and Group Senior Management level, which allows 24/7 on call support for all staff in the home.
· The shower list was removed on the day of inspection. Residents' care plans are being updated to reflect their personal preferences for bathing and showers.
· On a daily basis oversight of resident care will be overseen by the CNM or Staff nurses.
· A training session on Human Rights-Based Care will be held for all staff to ensure person-centred practice.
· An education session will be held for residents by the Activity Lead so residents are aware of using their voice and knowing their rights.
· Staff reminded during handover about seeking consent in all aspects of care including morning showers, assistance with care and respecting residents rights.
· The PIC/CNM/Senior nurse will oversee residents rights are respected at all times
· Allocation sheets to state offer all residents a shower/ bath or personal wash in accordance with their wishes daily .

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
· All inappropriate items, including excess mobility equipment and personal hygiene products, have been removed from bathrooms and communal areas.
· A full review of all storage areas will be completed.
· Items not required daily will be moved to off-site or alternative external storage.
· Storage protocols have been updated to ensure clinical and non-clinical items are stored separately to prevent cross-contamination.
· The PIC has introduced a weekly storage and environmental checklist to the weekly

management walk-around to ensure communal rooms remain accessible and clear of equipment.
· Flooring and chipped areas: The Registered Provider Representative, Head of Facilities and PIC have reviewed the storage and a plan is in place to enhance the storage in the centre.
· Refurbishment works are underway to update a number of communal bathrooms and replace worn floor.

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:
All residents care plans have been reviewed to ensure the resident's diet level has been cross-referenced with the most recent Dietician review and recommendations.
· The care plan and kitchen diet sheet have been updated with the correct information to ensure safety during mealtimes.
· A full audit of all residents referred to Speech and Language Therapy (SALT) and Dietetics is being conducted to ensure that 100% of specialist recommendations are transcribed into the electronic/paper care plans.
· Staff nurses have been re-educated on the requirement to update MDT recommendations to the resident's file and update the care plans following a consultation and to ensure that the older recommendations are taken out. The PIC and CNM will have oversight to ensure the process is implemented.
· The resident's falls risk assessment and "Restraint/Assistive Device" assessment have been formally updated to reflect the transition from a floor mat to a bed alarm.
· An audit of all restrictive practices has been completed to ensure compliance.
· All references to the discontinued floor mat have been removed from the care plan and daily flow sheets to prevent staff confusion. The CNM will audit residents weekly to ensure the assistive devices documented in their assessments match the equipment actually in use at the bedside.
· The importance of updating both assessment and care plan when equipment changes occur has been highlighted at the daily staff handover.

Regulation 9: Residents' rights	Substantially Compliant

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

· All inappropriate items, including excess mobility equipment and personal hygiene products, have been removed from bathrooms and communal areas.
· A full review of all storage areas will be completed. Items not required daily will be moved to off-site or alternative external storage.
· Storage protocols have been updated to ensure clinical and non-clinical items are stored separately to prevent cross-contamination
· The PIC/ CNM has introduced a weekly storage and environmental checklist to the weekly management walk-around to ensure communal rooms remain accessible and clear of equipment.
· Flooring and chipped areas: The Registered Provider Representative, Head of Facilities and PIC have reviewed the storage and a plan is in place to enhance the storage in the centre.
· An audit of all privacy screens has been completed and all screens which require replacing has been replaced.
· The shower list was removed on the day of inspection.
· An audit on all personal hygiene care plans has been completed with the staff and the residents to ensure that the residents' preferences for showers and personal care are known to all staff.
· All residents personal hygiene needs and preferences are discussed at handover on a daily basis.The CNM and PIC will complete spot checks on a daily basis.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	31/05/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	31/08/2026

	provided is safe, appropriate, consistent and effectively monitored.			
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	31/05/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	31/08/2026