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:	Orwell Private
Name of provider:	MCGA Limited
Address of centre:	112 Orwell Road, Rathgar, Dublin 6
Type of inspection:	Unannounced
Date of inspection:	11 May 2026
Centre ID:	OSV-0000078
Fieldwork ID:	MON-0050476

About the designated centre

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

Orwell Private is located in south Dublin close to local amenities such as bus routes, restaurants, and convenience stores. The centre can accommodate 170 residents, both male and female over the age of 18 years. They provide long term care, short term care, acquired brain injury care, convalescence care, respite and also care for people with dementia. The centre is made up of a period premises that has been adapted and extended to provide nursing care and support through a number of units. The units provide bedroom accommodation alongside communal areas including sitting and dining areas and a kitchenette that are homely in design. Bedroom accommodation is a mix of single and double rooms. The vast majority have en-suite facilities and a small number of bedrooms have shared bathrooms. Additionally on the premises there is a full time hair dressers, cafe, gym, library and training rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	155

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 11 May 2026	20:30hrs to 22:30hrs	Laurena Guinan	Lead
Tuesday 12 May 2026	08:00hrs to 16:05hrs	Laurena Guinan	Lead
Monday 11 May 2026	20:30hrs to 22:30hrs	Sharon Boyle	Support
Tuesday 12 May 2026	08:00hrs to 16:05hrs	Sharon Boyle	Support
Tuesday 12 May 2026	08:00hrs to 16:05hrs	Sarah Armstrong	Support

What residents told us and what inspectors observed

The majority of residents living in Orwell Private provided positive feedback on their experience of living in the centre. Most described it as a lovely place to live, and the inspectors saw many kind and respectful interactions between staff and residents throughout the course of the inspection. However, not all feedback from residents was positive and this will be reflected in the report. Inspectors spoke to 13 residents and two visitors over the course of the two days of the inspection.

This was an unannounced inspection conducted over two days, with night-time hours included on the first inspection day. The purpose of the inspection was to follow up on unsolicited information received by the Chief Inspector and monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the compliance plan from the previous inspection, and statutory notifications submitted to the office of the Chief Inspector of Social Services since the last inspection in January 2026. The overall findings of this inspection indicated that some of the concerns highlighted to the Chief Inspector by way of unsolicited information were substantiated, specifically in relation to staffing, manual handling practices, nutrition, and care and welfare of residents.

On arrival on the first day, which was during night-time hours, the inspectors conducted a walk-around of the units and compared staffing levels with the staff rosters provided to the inspectors by the night nurse in charge. Inspectors were informed by the day nurse in charge that all shifts were covered for the night time. They were advised that one staff member had reported absent from duty; however, this absence had been covered by a member of their own staff team. Inspectors were informed that messages were circulated to all staff to identify available staff to cover the absences, when required. Nevertheless, observations made during the walk around of the centre indicated that the staffing arrangements differed from those described. Inspectors observed that the night nurse in charge was required to undertake nursing duties in addition to supervising the care of residents. The impact of this staffing arrangement will be further discussed in the report.

On the second day, the inspectors conducted an introductory meeting with the person in charge, reviewed documents relevant to the inspection, and visited the units to observe staff practices and talk with residents, visitors and staff.

Orwell Private is divided into three multi-storey buildings that are interconnected through stairs and lifts. The buildings are named Orwell, Raglan and Elgin, and the floors on each unit are differentiated by colour. Long-term residents reside in each building, with a short-stay convalescence unit in the Elgin building. The premises were seen to be well maintained and clean. Residents spoken with were mostly happy with their bedrooms, however, one resident, who shared their room with another resident, reported that they had ongoing issues with the temperature of

their room that had not been fully resolved, despite being raised with management. The resident was managing the increased temperature by using a fan that they had purchased themselves. The inspectors found this room to be uncomfortably warm on the day of the inspection, despite the fan being used. On the Raglan Yellow unit, which accommodated residents who had acquired brain injuries, residents said that the door to their dining room did not allow wheelchairs to easily pass through. This resulted in residents' hands hitting off the door frame, and visible damage was caused by wheelchairs to the door and door frame. These issues were brought to the attention of the person in charge and one of the directors at the feedback meeting, and they committed to reviewing them. Residents had access to a variety of outdoor spaces such as gardens, courtyards and balconies.

The inspectors saw lunch being served on the second day of the inspection, and the meals appeared appetising and of good size. Residents could choose between a starter of chicken and vegetable soup or melon and grapes, followed by a choice of main, which included roast pork with apple sauce, baked cod, or plain chicken with vegetables and potatoes. For dessert, there was a choice of apple pie with crème anglaise or fresh fruit, jelly and ice-cream. Residents had the choice to dine in the dining room on their unit, or in their bedrooms. There was ample staff to assist residents, and they were seen to do so in a respectful manner. Residents spoken with described the food as 'excellent', and they said they were always offered a choice of meals.

Many residents spoke positively about the staff who cared for them. One resident introduced a member of staff to the inspectors, stating "this is a very good friend of mine, they are wonderful". When asked if staff were gentle and considerate towards them when assisting with their moving and handling needs, feedback from residents was mixed. Residents told the inspectors "they are, they are always very gentle, they're very good", "yes, they are kind, they take their time". However, one resident told inspectors that while most staff were gentle, there were some staff that could be rough with their manual handling.

Visitors were seen coming and going on the day of the inspection. Those spoken with told the inspectors that the staff were responsive when dealing with them, and they treated their loved one well. There were a number of areas in which residents could receive visitors, and visitors said that there were no restrictions on visiting times.

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

There was a clearly defined management structure in place, and while there were many good management systems observed, some required further review to ensure they were fully effective, particularly in relation to the oversight of staff practices, residents' concerns and care plans, as well as staffing levels and the submission of notifications.

MCGA Limited is the registered provider for Orwell Private. There was a person in charge who worked full-time in the centre and who was supported in their role by a deputy director of care and a team of clinical nurse managers. The company directors were also actively involved in the day-to-day management of the centre, and one of the directors was present and engaged with inspectors on the second day of the inspection. Staff nurses, healthcare assistants, activities coordinators, household, catering and maintenance staff made up the remainder of the staff team in the centre. Inspectors reviewed the professional registrations for all nursing staff and found that all staff who worked in the centre as nurses held valid registration with the Nursing and Midwifery Board of Ireland (NMBI).

The inspectors reviewed a sample of audits in the areas of care plans, nutrition, mealtimes and comfort checks. The audits showed a good standard of care while also identifying some of the gaps that were seen during the inspection. However, audits had not identified all of the gaps seen by inspectors. For example, care plan audits identified that care plans were not always person-centred, but had not identified discrepancies between residents' assessed needs and their care plans. This will be discussed under the relevant regulations.

A schedule of meetings showed a good system of communication within the centre. The meetings had action plans to address issues identified, and the person responsible for implementing the action plan was identified. For example, an action plan to improve care planning was recommended at a clinical governance meeting for Q1 2026, and this included protected time to be allocated to nurses to review and update care plans. This was seen to have been implemented, with shifts designated for care plan review on the rosters seen by inspectors. There was an annual review for 2025, and while this had been done in consultation with residents, no formal feedback had been sought from families. This was instead gathered through individual family meetings, the review of complaints and through informal engagement.

The inspectors reviewed the staff rosters and found that they were in line with staffing on each unit during the day shift. The exception to this was the allocation of the clinical nurse manager on night duty. On arrival at the centre on the first inspection day, the inspectors were told that there was an unexpected nurse absence which had been covered by regular staff. However, the allocation list provided to inspectors for that night identified a staff member who was rostered to work as a nurse in the convalescence unit had been re-allocated to cover the unexpected absence. The clinical nurse manager was then observed to be working on the convalescence unit in a nursing capacity. This was seen to be a recurrent practice, as the rosters reviewed for the two weeks prior to the inspection had the clinical nurse manager allocated to work in a nursing capacity on five other

occasions at night. Staff told inspectors that the clinical nurse manager was responsible for ensuring that breaks were staggered so that each unit was sufficiently staffed, and was relied upon to be available in the event of an emergency. Therefore, the clinical nurse manager was required to be working in a supervisory capacity to support and lead the staff at night.

Residents spoken with on different units told the inspectors that they often had to wait some time for assistance at night. Inspectors observed a resident who was unsupervised entering the bedroom of another resident while the nurse, who was alone on the unit, took a phone call. This was brought to the attention of the person in charge, who acknowledged the gap in skill-mix at night-time and explained that it was a short-term measure to fill staff vacancies. Nurses had been recruited to fill these vacancies, and once they commenced employment, the night-time clinical nurse manager would only work in a supervisory capacity.

Staff who spoke with inspectors spoke positively about the staffing levels on the units, stating that they felt the number of staff on duty each day was sufficient to meet the needs of the residents based on the residents' dependency levels and their preferred daily routines. However, feedback from residents indicated that staffing levels had an impact on the care they received, and having additional staff on duty would be beneficial. One resident told the inspectors that, while staff were usually quick when responding to requests for assistance, there were occasions during busier times, such as mornings and evenings, when they experienced delays. Another resident referred to the limited availability of staff in the centre, as they were not always supported to get up and dressed in a timely manner in the mornings. This resident informed inspectors that they had rung their call-bell twice and had been waiting in excess of 30 minutes for assistance to get up and dressed. The resident stated that a staff member had attended and advised they would return; however, no staff member returned to provide support. The resident told the inspectors that this was an ongoing issue and expressed dissatisfaction regarding the delays experienced. The resident further expressed that their preference was to get up and dressed at approximately 9:00am, but they were waiting for assistance that morning at 10.15am. On the night of the first inspection day, inspectors observed that call-bells were ringing for long periods. One resident was seen wandering into another resident’s bedroom and another resident was seen walking the corridor looking for staff assistance. Care staff were busy attending to residents, and the nursing handover from the day shift was delayed due to the nurse having to answer some call-bells.

Staff had access to a suite of training, and the inspectors saw a high level of compliance in areas such as safeguarding, manual handling, falls prevention and residents' rights. Residents spoken with said that 'staff were knowledgeable', and one resident said, 'they seem to know what they are doing', although one resident felt that 'some staff were rough when providing assistance'. Inspectors spoke with staff about appropriate manual handling practices and what steps would be followed if it was identified that staff were not adhering to correct practice. Staff demonstrated an understanding of correct manual handling practices and the potential risks, including safeguarding risks associated with inadequate practice.

There was a clear pathway to be followed in the event of an incidence of poor manual handling, which included escalation to a member of the management team.

An internal Information Technology system gave staff easy access to all current policies and procedures. Following a recent incident, the Serious Incident Review identified that additional staff training and education were required. This was seen to have been implemented. While a number of staff disciplinary interviews had been conducted following the incident, inspectors noted discrepancies between the information submitted to the Chief Inspector, the information contained in residents' records, and the information provided by the staff members interviewed.

The inspectors reviewed the submission of notifications with the person in charge and identified that three notifications had not been correctly submitted, as they were submitted as part of the quarterly returns but should have been submitted within two days of the event occurring. The criteria for the submission of these notifications were clarified with the person in charge to ensure that all future incidents were correctly categorised. The Chief Inspector had also not been notified of the unexpected death of a resident. The person in charge submitted all notifications retrospectively.

Regulation 15: Staffing

The registered provider had not ensured that the number and skill mix of staff was appropriate having regard to the needs of the residents and the size and layout of the centre. This was evidenced by the following:

- Feedback from residents was that they often had to wait for assistance from staff in the mornings and at night.
- Residents who were confused were seen wandering the corridors unsupervised during the night shift.
- Residents reported that call-bells were not always answered in a timely manner. This was also observed by the inspectors during the inspection.
- There was one clinical nurse manager allocated to provide supervision at night time; however, inspectors reviewed rosters and noted that the clinical nurse manager was regularly rostered to work in a nursing capacity in addition to a supervisory role.

Judgment: Not compliant

Regulation 16: Training and staff development

Notwithstanding some positive findings under this regulation, the inspectors observed that staff were not always appropriately supervised to ensure that care

was appropriately documented, and that increased supervision recommended through the disciplinary process was not actioned. This was evidenced by:

- A Serious Incident Review, and staff interviews conducted as part of this review, indicated that some staff had not been adequately supervised, and had not provided care in line with the provider's policy on post-falls care. While these findings had been acknowledged and addressed through enhanced training and education of staff in appropriate post-falls care, the supervision of staff at night-time had not been addressed and remained insufficient, as discussed under Regulation 15: Staffing.
- The supervision of staff practices with regard to the completion of documentation had not ensured that the care records of residents were correctly completed. For example:
    - The amount of food a resident had eaten was not always correctly documented.
    - Nursing notes were not always accurate and did not contain the appropriate information following an incident.
    - Two residents' care plans had inconsistent information. For example, where they had been assessed as requiring half hourly checks, their care plans had documented a requirement for hourly checks.
    - Comfort checks were not always documented in line with the resident's care plan.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place to ensure that the service provided was effectively monitored were insufficient. For example:

- The oversight systems in place to ensure that issues raised by residents regarding the premises were responded to appropriately, thus ensuring the comfort of all residents, were ineffective. For example, the increased temperature in the room for two residents was not addressed appropriately, nor to the residents' satisfaction.
- Audits had not identified issues seen by inspectors during the inspection. For example, gaps in care plan documentation had not been identified.
- The oversight systems in place to ensure that appropriate information was available to inform the disciplinary process following an incident had not identified inconsistencies in the information contained in the documents pertaining to the investigation.
- The oversight systems in place to monitor the risk register had not identified that the control measures in place to minimise the risk to one resident were overly restrictive, and did not uphold their rights.
- The oversight system for notifying the Chief Inspector of specific incidents was not effective, as outlined under Regulation 31: Notifications of incidents.

- The management systems in place to address all recommendations from the Serious incident review were found to be insufficient, as all actions had not been fully implemented regarding increased staff supervision in the centre to prevent further occurrences.
- The management systems in place did not ensure that there was sufficient staff available and with the required skill mix to ensure that care was provided to the residents in a timely manner, or that there was an effective oversight of staff practices.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all the notifications as required in the regulations had been submitted to the Chief Inspector. This included:

- Three notifications, which were required to be submitted within two days of the event occurring, had incorrectly been included in the quarterly notifications.
- One notification had not been received within the correct time frame.

Judgment: Not compliant

Quality and safety

Residents living in Orwell Private were seen to receive care from staff who were familiar with their needs. Nonetheless, inspectors identified gaps during the inspection in respect of the documentation of care plans, dietary intake, and the risk register, and inconsistencies were reported in the temperature of the meals served and in the promotion of rights-based care.

Residents told the inspectors that the choice and quality of food was very good. One resident said they had asked for more options such as pasta and rice dishes, and this had been accommodated. Where residents wished to dine at alternative meal times, this was respected by staff and fresh meals were provided from the kitchen upon the resident's request. Residents said that staff always accommodated them if they wished for food that was not on the menu, however, the temperature of the food varied between units. Some residents said that their food was served hot, while others said that it was 'always warm, but you wouldn't call it hot'. Nevertheless, not all residents had raised this as a concern with management. Residents were seen being offered a choice of condiments and drinks, and staff seemed familiar with their preferences. Staff assisted residents by sitting beside them and engaging them

in conversation, and some were heard to offer gentle encouragement to eat. Residents who had a history of weight loss or had a reduced appetite had their dietary intake recorded. The inspectors saw that although staff were knowledgeable about how much the residents had eaten, the amount was not always documented on their food chart in their records.

The inspectors reviewed the risk management policy, and it contained all the information as required by the regulations. There was a risk register in place, and the inspectors saw that a risk had been documented that resulted in a resident being unable to leave their floor. This was addressed with management at the feedback meeting, who clarified that there were measures in place to allow the resident to leave their floor and go outside should they so wish, and they committed to updating the risk register to reflect this.

The inspectors reviewed a sample of care plans from each unit. Validated assessment tools were used to develop care plans and care plans were reviewed at a minimum of four monthly intervals. However, the residents' care plans did not always reflect their assessment. Additionally, some residents who required regular comfort checks did not have these correctly recorded in their care notes.

Safeguarding care plans were in place for residents where required to ensure those residents were protected from the risk of abuse. Staff had appropriate training in safeguarding vulnerable adults and staff spoken with demonstrated a good knowledge of safeguarding principles. Residents were seen to be referred to health and social care professionals, such as a dietician and tissue viability nurse, as required.

Residents had access to a varied programme of activities in the centre. On the second day of inspection, residents could choose to participate in music, word games, aromatherapy, scrabble, music and reminiscence therapy. Residents also had access to a Fit for Life programme, gardening and therapeutic cooking. On the day, some residents were going on an outing to Rathfarnham Castle, which they told the inspectors they were looking forward to. Information was also displayed for residents about upcoming events in May, including a presentation from the Patient Advocacy Service (PAS), a tea party and a drum-tastic session. There were suitable communal and quiet spaces for residents, and residents had access to radio, television and newspapers to keep up to date with news and current affairs. Residents were also supported to access the services of independent advocates should they require them.

While some residents who provided negative feedback to inspectors said they had no problems informing staff of issues or making complaints, others told inspectors that they didn't feel comfortable speaking with staff about their concerns, with one resident telling the inspector "I don't want to get anyone in trouble, and I don't want it to come back on me". Residents' meetings were held every three months in the centre, and there was evidence that the feedback provided by residents was listened to and that issues were addressed; however, the oversight of this process had not always ensured concerns were resolved to the residents' satisfaction, as

discussed under Regulation 23: Governance and management and Regulation 9: Residents' rights.

Regulation 18: Food and nutrition

Inconsistencies were seen in the temperature of meals provided, and in the monitoring of residents' nutritional intake. For example, while the records of residents who had reduced appetite or required additional supplements had documented the meals provided, the amount of food eaten was not documented. This did not provide assurance that residents' dietary needs had been met.

Judgment: Substantially compliant

Regulation 26: Risk management

The registered provider had ensured that there was a risk management policy in place that contained the information as set out in the regulations.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The registered provider had ensured that assessments were completed and care plans implemented within 48 hours of a resident's admission. Care plans were reviewed at a minimum of four monthly intervals. However, issues with oversight of documentation is identified under Regulation 16: Training and staff development and Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 6: Health care

Residents were referred to health and social care professionals in a timely manner, and their recommendations were seen to be implemented in practice.

Judgment: Compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to protect residents from abuse. Where allegations of abuse were made, the person in charge had conducted an investigation into the incident.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had ensured that residents had adequate facilities and opportunities to engage in activities; however, residents were not always facilitated to exercise choice, as reported by residents who said that they waited for extended periods for assistance. This impacted on the residents' choices in their daily routine.

Additionally, the system by which residents were consulted about the organisation of the centre had not resolved all issues, or provided assurance to the residents that their opinions or requests would be dealt with in an impartial manner.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Orwell Private OSV-0000078

Inspection ID: MON-0050476

Date of inspection: 11/05/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider has reviewed staffing arrangements following the inspection and has implemented several measures to strengthen staffing levels, skill mix and night-time clinical oversight. An ongoing recruitment campaign has resulted in the appointment of additional registered nurses to strengthen the nursing workforce. Recruitment efforts remain ongoing, although they continue to be impacted by current constraints in employing non-EU staff. The Registered Provider remains committed to recruiting further registered nurses as suitable candidates become available to ensure safe, effective and sustainable staffing levels. To strengthen evening and night-time clinical support, one carer shift on each unit has been changed from an 8.00 am–8.00 pm shift to a 9.00 am–9.00 pm shift. This provides additional support during the transition to night duty staffing and enhances clinical oversight during the evening period. The Clinical Nurse Manager on night duty is now rostered in a supernumerary supervisory capacity on all night shifts, providing clinical leadership, oversight and support to staff. Should an unexpected absence occur, that cannot be covered by the centre's own staff, the Registered Provider has established arrangements with two approved nursing agencies. Any agency nurse engaged will receive a comprehensive induction and orientation using a structured induction checklist, completed by the Director of Nursing and the Night Clinical Nurse Manager, before undertaking clinical duties within the centre. Staffing levels and skill mix will continue to be reviewed in line with residents' assessed dependency, occupancy levels and service needs. The Person in Charge and senior management team will continue to monitor staffing rosters, call bell response times, resident feedback and quality indicators through the centre's governance framework to ensure residents receive timely, safe and person-centred care. Regular review of staffing arrangements will remain a standing agenda item at governance meetings to ensure staffing resources remain appropriate and responsive to residents' changing needs.	

Person Responsible: Person in Charge / Registered Provider
Completion Date: 30 November 2026

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 has strengthened the supervision and monitoring of staff to ensure that care is delivered and documented in accordance with the centre's policies, evidence-based practice and residents' assessed needs.
Additional administrative support has been introduced within the Education Department to increase the capacity of the Practice Development Nurse. This will enable the Practice Development Nurse to spend increased time in the clinical areas providing direct observation of practice, coaching, mentoring, competency assessment and supervision of staff.
A comprehensive Observation of Practice Audit Tool has been introduced to assess the application of training in practice through direct observation of care delivery. The audit focuses on person-centered care, professional practice, safe moving and handling, safeguarding, infection prevention and control, policy knowledge and the consistent application of best practice. Audit findings will be used to provide immediate coaching, identify further learning needs and support continuous quality improvement.
Refresher education will continue to be provided to nursing staff on documentation standards, including nursing notes, food and fluid records, comfort checks and care plan documentation.
The Registered Provider has also strengthened its succession planning Programme to recruit additional Assistant Directors of Nursing and Directors of Nursing, ensuring increased clinical leadership capacity across the service. In addition, mentor roles are being reintroduced to support staff development, reinforce best practice, promote competency and provide ongoing support to newly appointed and existing staff.
Audit outcomes, competency assessments and learning identified through supervision will be reviewed at Clinical Governance Meetings to ensure continuous monitoring, shared learning and sustained compliance.
Person Responsible: Person in Charge / Practice Development Nurse/ Clinical Nurse Management
Completion Date: Ongoing (with full implementation by 31 December 2026)

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 has strengthened the governance and oversight arrangements within the centre to ensure the service is effectively monitored and that quality improvement measures are embedded across all aspects of care delivery.

The centre’s audit programme has been comprehensively reviewed and strengthened to ensure that audits identify documentation deficits, care plan inconsistencies, practice issues and opportunities for service improvement. A programme of observational practice audits has also been introduced to provide direct oversight of staff practice, ensuring that knowledge and training are consistently translated into safe, evidence-based care. Audit findings will be monitored through the centre's Quality Improvement Programme, with action plans implemented, monitored and reviewed until sustained compliance is achieved.

Governance capacity has been further enhanced through increased administrative support within the Education Department, enabling the Practice Development Nurse to undertake increased clinical supervision, mentoring, competency assessment and direct observation of practice across all units.

A structured programme of clinical supervision has been strengthened across the centre to support staff in maintaining safe and effective practice. Where audits, observations of practice, incidents, complaints or documentation reviews identify non-adherence to policies, procedures or best practice, staff will receive immediate coaching, reflective discussion, mentoring and competency support from the Clinical Nurse Manager or the Practice Development Nurse. Follow-up observations, competency assessments and supervision will be undertaken to ensure improvements are embedded into everyday practice and sustained over time. Where appropriate, further education, performance management or disciplinary processes will be implemented in accordance with the centre's policies and procedures.

A succession planning programme has been implemented to strengthen clinical leadership through the recruitment of additional Assistant Directors of Nursing and Directors of Nursing. Mentor roles have also been reintroduced to provide ongoing support, coaching and professional development for nursing staff, reinforce best practice and support the consistent application of organisational policies and procedures.

Residents' concerns and feedback will continue to be reviewed promptly through the complaints process, residents' meetings, satisfaction surveys and daily management oversight. Actions arising will be documented, monitored and reviewed to ensure concerns are responded to appropriately and, where possible, resolved to residents' satisfaction.

Recommendations arising from Serious Incident Reviews will be reviewed by the senior management team, allocated to the appropriate responsible person and incorporated into the centre's Quality Improvement Programme. The implementation and effectiveness of actions will be monitored through Clinical Governance Meetings and verified through audit, direct observation of practice, supervision and competency assessment to ensure improvements are embedded into everyday practice and sustained over time.

Oversight of staffing, documentation, restrictive practices, statutory notifications, clinical risk and quality indicators will continue through regular management review, audit,

performance monitoring, clinical supervision and governance meetings. Trends, learning and quality improvement actions will be communicated to staff through governance meetings, safety huddles, supervision sessions and education programmes to promote continuous improvement and sustained regulatory compliance.
Person Responsible: Registered Provider / Person in Charge
Completion Date: 31 December 2026

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Registered Provider has reviewed and strengthened the centre's statutory notification process to ensure all notifiable incidents are submitted to the Chief Inspector within the required regulatory timeframes.
The Person in Charge and members of the senior management team have reviewed the notification requirements under the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and have received clarification regarding the categorization and submission of statutory notifications.
Compliance with statutory notification requirements will form part of the centre's governance and audit Programme and will be subject to ongoing management oversight to ensure sustained compliance.
Person Responsible: Person in Charge
Completion Date: Completed and ongoing

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The Registered Provider will continue to ensure that residents receive meals at an appropriate temperature across all units.
Food service arrangements have been reviewed, including meal service processes and food temperature monitoring. Resident feedback regarding meal temperature will continue to be monitored through residents' meetings, satisfaction surveys, compliments and complaints.
All equipment used for the hot holding of food is being reviewed and serviced as part of a planned maintenance Programme. Where equipment is identified as no longer meeting

operational requirements, appropriate replacement equipment will be sourced to ensure food is maintained at the correct serving temperature throughout meal service.
A weekly documented Nutritional Review Meeting, introduced in June 2026 and chaired by the person in charge , reviews all residents with a MUST score of 2 or above and those identified as being at high risk of malnutrition. Nutritional care plans, weight trends, dietary intake, prescribed supplements, referrals to dietetic services and nutritional interventions are reviewed to ensure appropriate measures are in place to support each resident's nutritional needs. Actions arising from these meetings are documented, implemented and monitored.
Nursing and care staff will receive refresher education on the accurate completion of food and fluid intake records to ensure that the nutritional intake of residents identified as being at nutritional risk is consistently and accurately documented.
Clinical Nurse Managers will undertake regular audits of food and fluid documentation to ensure compliance with the centre's policies. Findings from these audits will be reviewed through the Clinical Governance and Quality Improvement Programme, with learning shared with staff and additional support provided where required to ensure sustained compliance.
Person Responsible: Person in Charge / Head Chef / Clinical Nurse Managers
Completion Date: 30 September 2026

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Registered Provider will continue to promote and protect residents' rights by ensuring residents receive timely assistance to support their preferences, independence and individual choices.
The strengthened staffing arrangements, including enhanced evening nursing cover and a supernumerary Clinical Nurse Manager on all night shifts, will support residents to receive care and assistance at their preferred times and reduce delays in responding to requests for assistance.
Residents' meetings, satisfaction surveys, individual feedback, compliments and complaints will continue to be used to identify opportunities for service improvement. All concerns raised by residents will be documented, investigated, actioned and reviewed to ensure they are addressed promptly, fairly and, where possible, resolved to the residents' satisfaction.
The Person in Charge and Clinical Nurse Managers will regularly review resident feedback and concerns through the centre's governance arrangements to identify trends, monitor actions and ensure improvements are implemented and sustained.
Residents will continue to be encouraged to express their views and raise concerns in confidence. Staff will promote an open, transparent and person-centred culture, providing reassurance that all feedback is welcomed, taken seriously and responded to in a fair and respectful manner.

The effectiveness of these measures will be monitored through resident feedback, quality audits and the centre's governance framework to ensure residents' rights, dignity, choice, independence and quality of life continue to be promoted and upheld.
Person Responsible: Person in Charge / Clinical Nurse Managers
Completion Date: Ongoing

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/11/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/12/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/09/2026

Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	30/09/2026
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	31/12/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	20/07/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably	Substantially Compliant	Yellow	20/07/2026

	practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	20/07/2026