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:	Woodlawn Manor Nursing Home
Name of provider:	WL Woodlawn Care Services Ltd
Address of centre:	St Doolaghs House, Malahide Road, Balgriffin, Dublin 17
Type of inspection:	Unannounced
Date of inspection:	12 May 2026
Centre ID:	OSV-0008662
Fieldwork ID:	MON-0050479

About the designated centre

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

Woodlawn Manor Nursing Home is a purpose built designated centre built in 2023 and is spread over three floors, including a basement level for laundry and catering services. It is located in a suburban village in North Dublin. They provide 24 hour nursing care to male and female residents over the age of 18 with low, medium, and high/maximum dependency needs. They provide both short and long term care. There are places for 96 residents, with 96 single en-suite bedrooms. The centre has a range of communal areas inside, and enclosed garden area in the centre of the building.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	78

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 12 May 2026	07:00hrs to 18:00hrs	Geraldine Flannery	Lead
Tuesday 12 May 2026	07:00hrs to 18:00hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out by two inspectors of social services, which took place over one day. Inspectors spoke with residents, visitors and staff to gain insight into what it was like to live at Woodlawn Manor Nursing Home. The inspectors spent time observing the residents' daily life in the centre in order to understand their lived experience. Overall, the feedback was mixed, some positive and some negative, a synopsis of which will be reflected in this report. Inspectors spoke with more than 15 residents in detail and four visitors.

The majority of residents told the inspectors that they were happy living in the centre and reported satisfaction with the care they received. They said that staff were lovely, describing them as kind and quick to answer call-bells. However, some residents expressed significant concerns around certain aspects of the service.

Inspectors heard that there was a high staff turnover in the centre and the residents described the negative effects this had on them. They told inspectors that a lot of staff were leaving or were moved to a different floor, and how this made them feel anxious and uneasy. One resident described the emotional distress when the familiar staff they had come to know was changed and said 'I am devastated'.

Some residents linked the high turnover among nurses and carers with a lower quality of care. They said that the remaining staff appeared 'rushed and under a lot of pressure', with one resident describing the negative effect this had on their care, saying a staff member had been 'rough' while attending to personal care. The resident said that they voiced it at the time and it did not happen again.

Many residents informed the inspectors that they found it difficult to communicate with some staff. They said that on several occasions some staff 'did not know what I was saying' and another resident said 'I have no idea what some staff are saying to me'. Some residents said that on occasions staff were talking in their native language, which they did not understand and this made them think they are talking about them, or they felt ignored. This was also confirmed by some staff who said that on occasions, other staff talk in their native language, which they know is against policy.

Residents said that quality of care was 'not about having the right numbers but about having the right staff'. They went on to say how they felt things had gone downhill significantly in the past year saying, 'it had been very good and I was very happy living here, but it's going on for too long and I am worried about the future'. Residents said that management should do more to retain the good staff, as they 'really make a difference to the quality of life for the residents'. Some residents said that communication from the management had been 'very poor so far' and they no longer knew who to complain to, as there had been so many changes.

Inspectors heard about the dissatisfaction from family members about the staff instability. Some visitors attributed staff turnover to less individualised attention and accuracy for residents. One family member described a near-miss relating to a medication error by unfamiliar staff, which was only identified when the family member noticed the error. Inspectors followed up on this incident and saw that it was appropriately documented and managed by the management team, including providing medication refresher training for the staff involved, to prevent recurrence.

Staff in general described the morale as low within the team. They told inspectors that due to staff leaving the remaining employees often had to cover shortages which left some staff feeling 'burnt-out' and which created instability and frustration. For example, some staff reported feeling frustrated at the lack of staff supervision, which meant that poor practices such as inappropriate manual handling occurred at times. Staff told inspectors that there was a lack of communication from the leadership about changes in the centre and inspectors heard how this was interpreted negatively by staff. They said that due to the 'silence from management' they had to rely on informal information, increasing confusion and damaging trust in the leadership team.

Notwithstanding the mixed feedback, the inspectors observed numerous courteous interactions. For example, staff were observed sitting down and assisting residents at meal time in a patient manner and engaging in positive conversation. One healthcare assistant was heard describing to the resident how a new management team has started and they were hoping this would have a positive impact on the centre.

Another example of a kind interaction was when a resident told the inspectors how they had requested to go to the toilet early in the morning and after that, when they could not sleep, the nurse had brought them 'a nice cup of tea in bed which they greatly enjoyed'.

On the day of inspection, some residents were seen enjoying their meals in the dining room, while others chose to eat in their bedrooms. Residents confirmed that there was always a choice of meals, and food and snacks were available at all times including out-of-hours. Despite the largely positive feedback received in respect of the food served, there were many concerns raised around the temperature of the food. The comments included, 'the food is not hot enough' and often 'hard'. Inspectors followed up on this and, while it was not seen to be an issue on the day of inspection, management were made aware of the residents' feedback.

Throughout the day residents were observed being encouraged to participate in various activities including chair yoga, gentle exercises, ball playing, hand massages, quizzes and pet therapy. However some residents who spoke with the inspectors mentioned that they would like more opportunities to go outside, and more encouragement for walking and staying active.

An activity schedule was displayed, and designated staff were assigned to facilitate activities. Mass was shown live on the television in the communal areas on the first floor. However, this was a busy area with residents coming and going and one

resident said they would like to have a quiet place to kneel or say a prayer. A large Oratory was available in the centre, which was warm and appropriately equipped, however some residents were not aware of the space or encouraged to use it. A chaplain was seen after the Mass going around the centre and offering Holy Communion to all residents who wished.

In the morning, the inspectors observed the handover process (passing on the relevant information from the night time staff to the day-time staff) on each of the units. While the handover process was consistent between the two floors, it did not ensure that all staff were provided with all essential information in respect of managing residents' needs and will be described later in the report.

While the centre provided a homely environment for residents and acknowledging that the provider had taken some action to address aspects of the care environment since the previous inspection, inspectors observed that there were still some deficits in respect of the premises and infection prevention and control (IPC) practices and these will be detailed further in the report.

The next two sections of the report detail the findings in relation to the capacity and capability of the centre and describes how these arrangements support the quality and safety of the service provided to the residents. The levels of compliance are detailed under the relevant regulations.

Capacity and capability

Overall, inspectors found that the provider was making some progress towards improved regulatory compliance to enhance the quality of life for the residents in the centre. As evidenced in the first section of this report, there remained significant concerns regarding the stability, quality of residents' care and staff morale. Consequently, further work was required to strengthen the oversight of the service to ensure a safe quality service was provided at all times, as further detailed in the report.

The findings from inspections of 17 February 2026 and 13 March 2026 were that the registered provider had failed to ensure that there was an appropriate governance and management structure in place to meet the care and welfare needs of residents and effectively safeguard the residents living in the centre.This unannounced risk inspection was carried out by inspectors of social service to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 to 2025 (as amended).
- review the detail of a representation, submitted by the provider following the issuing of a notice of proposed decision to attach a restrictive condition to the registration to stop admissions to the designated centre.

- review unsolicited information received by the Chief Inspector, pertaining to serious concerns regarding the care and safety of residents. This information was partially substantiated on this inspection.

This inspection found that the registered provider had taken prompt action and restored the governance and management structure in the centre since the last inspection in March 2026. The provider had appointed a new local management team, which now included a person in charge (PIC) and an assistant director of nursing (ADON).

However, inspectors found that due to the extent of the recent changes to the organisational structure and the high levels of staff turnover, key management personnel appointed were not fully established and required additional time to develop and make the necessary changes to embed effective oversight of the service.

The registered provider is WL Woodlawn Care Services Limited. A director provides operational oversight and support to the local management team. The person in charge had responsibility for the day-to-day operations of the centre and was supported in their role by an assistant director of nursing (ADON) and four clinical nurse managers. Also in support were a team of nurses, care assistants, activities, catering, household, administration and maintenance staff.

Notwithstanding that there were sufficient numbers of healthcare staff on duty on the day of inspection, housekeeping resources required review. In addition, there was not sufficient clinical supervision in place to ensure that residents' needs were met in a timely and person-centred manner. For example, staff did not consistently implement in practice care interventions that had been outlined in the residents care plans. Also, there was a lack of supervision in relation to the quality and accuracy of records maintained by staff. Since January 2026 there had been a high turnover in staff for all roles, with 22 staff leaving and 15 new staff starting in the centre. This impacted on the ability of the new governance and management team to stabilise and effectively supervise staff practices to ensure continuity and high quality and safety of care.

The annual review of the quality and safety of the service for 2025 and quality improvement plan for 2026 was available for review. There was evidence that it was prepared in consultation with residents and their families.

Documents were available for review, such as the statement of purpose, contracts of care and complaint procedure, and were fully compliant with the legislative requirements.

Regulation 14: Persons in charge

A suitably qualified and experienced registered nurse was in charge of the centre on a full-time basis. They recently commenced the post of the person in charge on 5

May 2026. They were supported by a company director and an assistant director of nursing who also commenced post in May 2026 and would deputise in the absence of the person in charge.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection there were adequate levels of nursing and care staff on duty to ensure the safe delivery of care to residents. All nurses held a valid Nursing and Midwifery Board of Ireland (NMBI) registration.

However, the housekeeping resources required re-evaluation, given the large footprint of the designated centre that required to be cleaned on a regular basis. From talking with housekeeping staff, observing practices and a review of records, inspectors found that there were insufficient staff allocated on five days of the week, therefore deep cleaning of the centre during these days, if required, was not completed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a well-maintained training matrix in place that set out when each staff member had completed training, and when they were due to complete refresher training.

However, staff supervision arrangements were not appropriate to protect and promote the care and welfare of residents at all times. This was evidenced by the failure to;

- Provide effective oversight of the residents' clinical documentation to ensure that residents' assessments and care plans were implemented in practice.
- Ensure nursing care records were appropriately maintained and reflected the care provided to residents on a daily basis.
- Ensure communication of key clinical information to staff including safeguarding or visiting arrangements.
- Ensure clear lines of communication, responsibility and accountability. Some staff who spoke with the inspectors reported that due to so many recent changes they no longer knew who to ask for issues relating to rostering hours.

- Staff were aware of local arrangements in respect of uniform policy or speaking in native language in front of residents, however due to supervision failures such practices continued.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents included all the information specified in paragraph 3 of Schedule 3 in the Care and Welfare of Residents in Designated Centres 2013. This ensured that comprehensive records were maintained of a resident's occupancy in the centre.

Judgment: Compliant

Regulation 21: Records

The registered provider ensured that the records set out in Schedules 2, 3 and 4 were available to the inspectors on the day of inspection and the management of the records was found to be in line with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the improvements to the management structure, the management systems in place were not yet sufficiently developed to ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- The recent implementation of a new organisational structure in the centre meant that the management team were not fully established, and required additional time to embed the necessary change to ensure the effective oversight of the centre and promote a positive culture. Inspectors continued to observe ineffective supervision arrangements including poor staff practice in respect of staff not changing from their uniform after finishing their shift, which was a recurrent finding over the last two inspections, with the potential to adversely impact the safety of the residents.
- From an operational perspective, the combination of a new management team and a very high staff turnover over a short period of time had a significant impact on the service. For example, as evidenced in the first

section of this report there was reduced continuity of care, impaired communication and weakened relationships between the residents and staff, diminished job satisfaction among staff, all impacting the residents' wellbeing and safety.

- The auditting system was not yet fully developed in all areas and there was ineffective management oversight of clinical documentation, including the assessment of residents' needs and care plans.
- The management systems in place to oversee the cleanliness and maintenance of the physical environment was not fully effective, as evidenced under Regulation 17: Premises.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

There was a contract of care available for all residents, providing evidence that the registered provider had agreed in writing with each resident, on admission the terms of admission to the centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose relating to the designated centre containing all information set out in Schedule 1.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure in place met the requirements of the regulation. It included information on advocacy services and the nominated complaint officer had the suitable training to deal with complaints.

Judgment: Compliant

Quality and safety

Overall, inspectors found that while staff were doing their best to ensure residents received good care and were supported to exercise choice, deficits outlined in the capacity and capability section adversely impacted the quality and safety of the care provided.

Residents' care records were maintained on an electronic system. Since the last inspection, the provider had transitioned to one electronic system. While the signal and access to Internet had significantly improved, the inspectors observed and several staff reported that on occasion the system continued to be slow. This delayed care or meant that recording of notes was not possible in a timely manner.

The inspectors reviewed a sample of 11 residents' care plans related to safeguarding, nutrition, skin integrity, mobility, communication, restrictive practices, safeguarding and behavioural care plans and found that while many care plans were person-centred, there was also evidence that these care plans were not consistently implemented in practice. There was evidence of family involvement in the management of care plans, and care plans were initiated and reviewed at regular intervals and in line with regulatory requirements. Further information is detailed under Regulation 5: Individual assessments and care plans.

Staff were observed to interact and respond to residents with responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) in a manner that was effective and patient. Residents with additional responsive behavioural needs also had appropriate care plans in place to guide staff and document episodes of occurrence. While there was evidence of multidisciplinary involvement, consultation and residents' consent in respect of restrictive practices in place, some gaps were also identified as outlined under Regulation 7: Managing behaviours that challenge.

Residents with communication needs had very detailed care plans in place which were very person-centred and were reviewed and updated at regular intervals.

Residents' bedrooms were personalised and were cleaned on a regular basis and residents reported satisfaction with their bedrooms. However, while overall the centre provided a homely and welcoming environment, there continued to be some malodours in the sluice facilities and along corridors, and inspectors were informed of plans to change the flooring in some parts of the centre. This had been a recurrent finding over the past three inspections. Window cleaning services were in the centre on the day of the inspection and some of the residents described how delighted they were to get the windows cleaned to their bedrooms. On this inspection, equipment was found to be in good working order. Progress had been made in respect of refurbishing the first floor balcony, with new raised flower planters and garden furniture provided for the residents.

Regulation 10: Communication difficulties

Residents with communication needs had their needs met and their care plans clearly outlined any hearing, speech, cognition or vision impairments and outlined person-centred interventions to support their needs.

Judgment: Compliant

Regulation 17: Premises

Despite some works being carried out by the provider since the last inspection, the premises were not in compliance with Schedule 6 of the regulations, for example;

- Malodours were still evident in the centre. The sluice room on ground floor had a foul smell and the ventilation system did not appear to be effective. This was a repeat finding.
- General wear-and-tear was observed in the centre. The day room on the first floor and numerous bedrooms had chipped paint and unsightly markings on the walls. Some walls had been repaired, but they were still awaiting to be painted and these detracted from the homely environment.

Judgment: Substantially compliant

Regulation 27: Infection control

The inspectors found that the registered provider had not ensured that some procedures were consistent with the National Standards for infection prevention and control in community services (2018). The following findings required action:

- There was no person nominated as the infection prevention and control (IPC) lead at the centre. Inspectors acknowledge that the person in charge had a plan to appoint the role imminently.
- Staff practices were not in line with best infection prevention and control practice. Staff were observed leaving work in their uniform, which was a repeat finding. Staff were also observed not using staff rooms to change or store their personal belongings. For example a staff' members coat and backpack were seen on a commode in a residents' communal bathroom. This posed a significant risk of cross-contamination.
- Shortages and ineffective allocation of housekeeping resources adversely impacted the cleanliness on the ground floor. Inspectors were informed that

no deep cleaning of bedrooms was being completed as a result of the reduction in the housekeeping staff.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

While care plans were in place for each resident which identified their needs, there continued to be significant action required to ensure they were consistent and were implemented in practice. For example:

- When talking with the inspectors, healthcare staff were not aware of key interventions in respect of safeguarding or visiting arrangements for residents. While the information was included in the care plan, it was not included in the handover sheet that healthcare assistants had and whom were providing the care. Therefore, staff did not implement care interventions meant to protect the residents as outlined in residents' care plans.
- Some care plans contained conflicting information in respect of residents' care needs. For example, some care plans outlined that residents were for assistance with the standing hoist but also full hoist, or a resident had a score of MUST 0 (Malnutritional Universal Screening Tool assessment) as well as a MUST 1. On occasions, care plans were used as a chronology of completed actions and not supportive interventions required to meet a need, which was confusing and posed a risk that the care provided would not be based on the most up-to-date assessment or recommendation from healthcare professionals.
- Interventions outlined in the care plan for residents assessed as being at risk or having a skin injury, were not evidenced to be implemented in practice. There were numerous gaps in the repositioning records or safety checks, which did not provide assurance that these interventions were being carried out.
- Care plans for residents using restrictive measures such as bedrails, lap-belts were in place, and contained comprehensive details; however they were not informed by risk assessments. Staff reported that such assessments had historically been in place, but they had been dropped during the transition from one electronic record to another, as the new process was cumbersome and involved many steps. The electronic care record system continued to pose challenges to staff.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

While staff had training and were knowledgeable in the management of responsive behaviours, the oversight of restrictive practices was not sufficiently robust. There was no up-to-date restraint register in the centre, and from the sample reviewed inspectors found that not all residents had been assessed for the use for restrictive practices, as outlined under Regulation 5: Individual assessment and care planning.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken all reasonable steps to protect residents from abuse. The newly appointed person in charge was the designated safeguarding officer and understood their responsibilities assigned under this role. Staff demonstrated good knowledge of safeguarding principles and had received relevant training to support them in their work.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Woodlawn Manor Nursing Home OSV-0008662

Inspection ID: MON-0050479

Date of inspection: 12/05/2026

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A full review of housekeeping staffing requirements has been completed by PIC and ADON to ensure that staffing levels are aligned with the cleaning and environmental hygiene needs of the centre across all seven days. Housekeeping rosters have been revised to provide a more equal distribution of staffing resources during weekdays and weekends. Completed on 18th May 2026 • The Person in Charge and Assistant Director of Nursing will monitor housekeeping workloads and staffing levels on an ongoing basis to ensure that adequate resources are available to maintain a clean, safe, and comfortable environment for residents at all times. • The Housekeeping Supervisor will monitor the completion of daily cleaning duties and deep-cleaning schedules through regular audits, supervision, and review of cleaning records. • A monthly Environmental IPC audit was introduced in June 2026 to strengthen oversight and monitoring of environmental hygiene practices. This audit will be monitored by the IPC Lead who ensure action plan are followed up.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC strengthened staff supervision arrangements to ensure effective oversight of clinical practice, communication systems and staff performance. A comprehensive audit on Staff Supervision, Communication and Clinical Documentation Audit will be	

implemented by 30th June 2026. This audit will assess the quality of resident documentation, implementation of care plans, communication of key clinical information, staff supervision arrangements, accountability structures and adherence to centre policies. The audit will be completed monthly by the CNMs/ADON/DON with findings reviewed through the centre's Clinical governance and management meetings.
• To improve the quality and oversight of clinical documentation, all nursing staff will complete refresher training in professional documentation and record-keeping by 15th July 2026.
• Daily review of nursing records will be completed by the nurses' oversight by CNMs on duty at the end of each shift.
• Communication processes will be strengthened to ensure that key clinical information, including safeguarding concerns, visiting arrangements and significant changes in residents' needs, is effectively communicated to all staff. This has now been implemented through safety huddle, an updated handover document and a communication log requiring staff sign off.
• All clinical staff will have access to the care plans of the residents with the introduction of a new electronic documentation system which will be implemented by 31st July 2026.
• Clear lines of accountability and responsibility has been re-established in the centre. An updated organisational structure and staff responsibility has been communicated to all staff through dedicated staff meetings and clarified reporting relationships, rostering responsibilities and escalation pathways which was completed in May 2026.
• A weekly walkaround by CNMs/ADON/DON has been introduced to ensure consistent oversight of staff practice which includes uniform policy and speaking in native language and the observations and action plan will be documented.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• There is a new senior management structure in place with RPR support to the PIC, ADON, and CNMs. The management team is now fully established and embedded the necessary change to ensure the effective oversight of the centre and promote a positive culture with weekly teams meetings established immediately to oversee clinical care, staffing, safeguarding, and environmental standards. Minutes of the meeting with action plans are documented.
• Staff across all roles (nursing, healthcare assistants, kitchen, activity and housekeeping) have been instructed that uniforms must not be worn to and from work, in line with national guidance and organisational policy.
• A directive has been sent to all staff by email regarding the dress code and uniform. A toolbox talk on dress code and uniform has now been implemented. The compliance will be monitored through supervision and spot checks by the PIC and IPC Lead.
• A workforce stabilisation plan has now been implemented to improve continuity of care,

including consistent staff allocation to residents and structured induction for all new staff. Staffing continuity will be reviewed monthly by PIC, ADON and RPR.
• A new audit schedule with new audit templates has now been implemented covering clinical documentation, care plans and safeguarding.
• A monthly IPC environmental audit and a monthly equipment audit have now been implemented from June 2026. All identified maintenance and cleanliness issues are recorded and resolved within the timeframes.
• A monthly Clinical Governance Meeting chaired by PIC commenced in June 2026 to review audit outcomes, incidents, staffing levels, and quality indicators.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A qualified contractor will assess the ground floor sluice room ventilation system to identify the cause of the persistent malodour and determine any required remedial actions by 10th July 2026.
• All recommended repairs, servicing, or replacement works to the ventilation system will be completed by 31st July 2026 to ensure effective odour control and ventilation within the sluice room.
• Pending completion of these works, PIC implemented a weekly walkaround inspection and monitor environmental checks of the sluice room and adjacent areas to identify and address any malodours promptly. Records of these checks will be maintained and reviewed monthly by PIC and RPR.
• A planned programme of painting and decorative works has been completed to address general wear and tear, chipped paint, wall markings, and unfinished repair works identified during the inspection.
• The PIC will review progress against the maintenance schedule on a monthly basis and report updates to the Provider Representative to ensure timely completion of all actions.
• A quarterly premises review programme will be introduced from 15th July 2026 to monitor the condition of the environment, identify wear-and-tear at an early stage, and ensure ongoing compliance with Regulation 17 and Schedule 6 requirements.
• Residents' feedback regarding the environment, comfort, cleanliness and maintenance of the centre will be sought through residents' meeting, satisfaction surveys and engagement with residents to ensure the environment continues to meet their needs and preferences. This is documented in the weekly walkarounds, resident's meeting minutes and the ongoing residents survey.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• An Infection Prevention and Control (IPC) Lead was formally appointed for the designated centre on 25th May 2026. The IPC Lead will be responsible for overseeing infection prevention and control practices, monitoring compliance, providing guidance to staff, and reporting findings to the Person in Charge and Provider Representative.

• An IPC committee has been created within the centre and there will be monthly IPC Committee meeting from July 2026 chaired by IPC Lead.

• All staff will receive refresher training on infection prevention and control practices, including uniform policy, hand hygiene, prevention of cross-contamination, and the appropriate storage of personal belongings, by 15th July 2026. Attendance records will be maintained and monitored by the Person in Charge.

• All staff has been reminded that uniforms must not be worn outside the workplace and that personal belongings must be stored only in designated staff areas. Compliance will be monitored through daily supervision by the IPC Lead and monthly IPC audits.

• Immediate action has been taken to ensure that personal items are not stored in resident areas. The PIC/ADON will conduct weekly walkarounds for a period of three months and then monthly to monitor compliance and address any concerns identified. Documentation on file.

• A full review of housekeeping staffing requirements has been completed by PIC to ensure that staffing levels are aligned with the cleaning and environmental hygiene needs of the centre across all seven days. Housekeeping rosters have been revised ADON to provide a more equal distribution of staffing resources during weekdays and weekends. Completed on 18th May 2026

• A programme of deep cleaning for all bedrooms and identified high-risk areas will commence by 29th June 2026 and be completed by 31st July 2026. Records of completed deep cleaning will be maintained and reviewed by the Person in Charge.

• Monthly infection prevention and control audits will be undertaken by the CNMs from June 2026 onwards. Audit findings, actions required, and progress updates will be reviewed at Clinical Governance meetings to ensure sustained compliance.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• A comprehensive review of residents' assessments, care plans and associated risk assessments commenced on 25/06/2026 to ensure all documentation accurately reflects residents' current assessed needs, preferences, risks and required interventions.

• Communication processes will be strengthened to ensure that key clinical information, including safeguarding concerns, visiting arrangements, behavioural support plans,

restrictive practices and other risk management interventions, is effectively communicated to all staff. This will be implemented through safety huddle, an updated handover document and a communication log requiring staff sign off.
• All clinical staff will have access to the care plans of the residents with the introduction of the new electronic documentation system which is currently being implemented and will be completed by 31st July 2026.
• Nursing staff will receive refresher training on care planning, documentation standards, and person-centred care by 15th July 2026. The training will focus on ensuring care plans contain clear interventions, are informed by current assessments, and are regularly updated following changes in residents' needs or recommendations from healthcare professionals.
• A full audit of care plans will be undertaken by 31st July 2026 to identify and rectify conflicting information, including discrepancies relating to moving and handling requirements, nutritional assessments, and other clinical risks. Any inconsistencies identified will be corrected immediately by nurses/CNMs, and reviewed by the ADON/PIC
• All residents identified as being at risk of skin breakdown or requiring repositioning will have their care plans reviewed by 15th July 2026 to ensure that interventions are clearly documented and aligned with current assessments and specialist recommendations. Repositioning schedules, safety checks and skin integrity monitoring records will be reviewed daily by nursing staff and monitored by CNMs through clinical audit.
• A review of all restrictive practices in the centre has been completed by CNM in May 2026. Individual risk assessments supporting the use of restrictive measures, including bedrails, lap belts and other restrictive interventions, will be completed or updated by 15 July 2026. All restrictive practices will be reviewed quarterly and recorded within the Restrictive Practice Register.
• The challenges associated with the electronic care record system is under review. Documentation processes will be streamlined to ensure all mandatory risk assessments are completed and maintained within the system.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• A review of all restrictive practices in the centre has been completed by CNM. An updated restrictive practice register has been established and will maintain to provide effective oversight of all restrictive practices in use by PIC.
• A monthly review of restrictive practice register has been introduced by the PIC to monitor compliance, ensure the register remains current, identify opportunities to reduce or eliminate restrictive practices, and confirm that all required documentation is completed by CNM and reviewed by PIC. Findings from these reviews will be discussed at clinical governance meetings, with any actions identified assigned and monitored to completion.

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	30/06/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/07/2026
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	Substantially Compliant	Yellow	31/07/2026

	the matters set out in Schedule 6.			
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	30/06/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Orange	31/07/2026
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).	Not Compliant	Orange	31/07/2026
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of	Substantially Compliant	Yellow	30/06/2026

	Health from time to time.			