



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	An Teaghlach Uilinn Nursing Home
Name of provider:	Knegare Nursing Home Holdings Ltd
Address of centre:	Kilrainey, Moycullen, Galway
Type of inspection:	Unannounced
Date of inspection:	02 March 2026
Centre ID:	OSV-0000309
Fieldwork ID:	MON-0049401

About the designated centre

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

An Teaghlach Uilinn Nursing Home is a purpose-built designated centre for older people. Residents are accommodated in single and twin bedrooms. A variety of communal rooms are provided for residents' use, including sitting, dining and recreational facilities. The centre is located close to Moycullen village, Galway. Residents have access to a secure enclosed courtyard. The centre provides accommodation for a maximum of 75 male and female residents, over 18 years of age. The service provides care to residents with conditions that affect their physical and psychological function. Each resident's dependency needs are regularly assessed to ensure their care needs are met.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	53
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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 2 March 2026	07:30hrs to 18:30hrs	Rachel Seoighthe	Lead
Monday 2 March 2026	07:30hrs to 18:30hrs	Brid McGoldrick	Support
Monday 2 March 2026	07:30hrs to 18:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out over one day. Residents living in the centre were complimentary about the quality of food, the choice of menu, improvements in the laundry service, and the kindness of staff, when available. Residents spoke positively about the management team. However, some residents and visitors expressed concern with some aspects of the service, which they largely attributed to a high turnover of staff. Some residents reported that staff did not always know their individual needs and wishes. They described communication difficulties, and delays in care delivery.

An Teaghlach Uilinn provides long term care for both male and female adults with a range of dependencies and needs. The centre is situated in a residential area on the outskirts of Moycullen Village, Co. Galway. The designated centre is registered to accommodate a maximum of 53 residents in single and twin rooms, all of which have en-suite facilities. The centre was fully occupied on the day of the inspection.

On arrival to the centre, inspectors were welcomed by a member of staff, and were joined shortly after by the assistant director of nursing, who facilitated the inspection. Inspectors attended a daily handover of care, after which, an introductory meeting was commenced, followed by a walkabout of the premises. This gave inspectors the opportunity to meet with residents and staff. During this time, inspectors observed that a number of residents were being assisted with their care needs, and some residents were attending the communal areas.

The centre is a two-storey building which was spacious, with a variety of communal rooms and a secure outdoor area. Resident bedroom and living accommodation was arranged over two floors. Many residents' bedrooms were personalised with their items of significance, including their photographs, artwork and ornaments.

Residents who were able to speak with the inspectors were mostly happy with the care and services provided in this centre and gave positive feedback about the staff and management team. One resident told inspectors that they 'loved' living in the centre, and another resident described being 'very happy'. Inspectors were informed that 'the food is lovely, we get too much' and residents were satisfied that they could get a cup of tea 'at any time'. However, other residents informed the inspectors that some staff were not familiar with how they liked their cup of tea, as the staff were 'always changing'. One resident described challenges in communicating with staff. Inspectors observed the staff interacting with residents and, for the most part, residents were seen to be relaxed and comfortable in the company of staff. However, inspectors noted an occasion where a residents' choice in relation to an aspect of their daily routine was not being upheld.

Inspectors brought a number of issues to the attention of staff throughout the inspection, including concerns of a fluid spillage, observed on the floor of a resident

bedroom, which was not addressed in a timely manner. Inspectors noted that the wall surface in one resident's bedroom remained visibly soiled throughout the day of the inspection. Despite several discussions with the management team in relation to this, the residents' bedroom was not cleaned until late afternoon, and the resident was required to eat their lunch-time meal in an unhygienic environment.

Inspectors witnessed occasions where a lack of appropriate supervision resulted in delays in the direct provision of care. Although staff made efforts to respond to resident needs promptly, the allocation of staffing resources did not always ensure that resident needs could be met in a timely manner. On the morning of the inspection, inspectors observed residents who required the assistance of two staff, waiting extended periods of time for personal care. In the afternoon, inspectors found that there were limited staff available to supervise residents and respond to a resident who required urgent assistance in one area of the centre. Inspectors acknowledge that there was an ongoing recruitment process in progress, however newly hired staff were observed to be working unsupervised on the day of the inspection.

Inspectors observed that, overall, the centre generally provided a homely environment for residents, however, not all areas of the premises were kept in a good state of repair. Inspectors noted damp and water damage on wall surfaces throughout the Holly unit, on the ground floor. This had been observed on a previous inspection of the centre.

A new janitorial unit had been installed in the housekeeping room. The main kitchen was of adequate size to cater for resident's needs. These areas were found to be clean and tidy. However, some of the ancillary facilities did not support effective infection prevention and control. The infrastructure and size of the small on-site laundry did not support the functional separation of the clean and dirty phases of the laundering process.

There was only one bedpan washer in the centre, which was located on the ground floor. There was no risk assessment completed to ensure that appropriate risk control measures were in place. The location of bedpan washer did not minimise travel distances for staff from resident rooms, increasing the risk of spillages and cross contamination, and impairing working efficiencies.

Conveniently located, alcohol-based product dispensers were readily available within bedrooms and on corridors. Clinical hand washing sinks were also available in the ground floor sluice room, the housekeeping room, and at the nurse's station to support effective hand hygiene. These complied with current recommended specifications for clinical hand hygiene sinks. However, there was a limited number of dedicated clinical hand wash sinks within close proximity of resident bedrooms, and the sinks in the residents' bedrooms and ensuite bathrooms were dual purpose, meaning they were used by residents and staff.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how

these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection conducted by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulation 2013 (as amended), and to follow up on the findings of the previous inspection in September 2025. This inspection found that the providers systems of oversight were not sufficiently robust to ensure that risks to resident safety and welfare were managed effectively. This inspection also found that registered provider failed to demonstrate sustained compliance with key regulations, particularly in relation to governance and management, records, assessments and care plans, protection and residents' rights. The actions committed to in a compliance plan, submitted to the Chief Inspector following the previous inspection, had not been fully completed.

Following an inspection of the centre in September 2025, the registered provider was required to confirm the urgent actions they would take to ensure the effective supervision of staff, so that all care was delivered in line with the residents' care plan, and records of care delivery were accurately maintained, by dates specified by the Chief Inspector. However, this inspection found repeated non-compliance in relation to the training and supervision of staff. Consequently, inspectors found that the needs of residents were not always known to the nursing and care staff, staff were not familiar with the electronic care record system, daily care records were not accurately maintained, and resident care plans were not consistently implemented. Significant non-compliance was also found in relation to protection, residents' rights, and governance and management.

Following this inspection, the provider was required to submit an urgent compliance plan to the Office of the Chief Inspector, to give assurance that:

- the registered provider, in so far as in reasonably practical, arranged to meet the assessed needs of each resident in the centre.
- the registered provider took all reasonable measures to safeguard residents from abuse, and ensure the consistent implementation of safeguarding policies and procedures.
- there were robust arrangements in place to appropriately supervise staff, so that all care was delivered in line with the resident's' care plan, and that records of care delivery were accurately maintained.
- there were effective management oversight systems in place, to ensure oversight of staff supervision and allocation.

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

Knegare Nursing Homes Limited is the registered provider for An Teaghlach Uilinn Nursing Home. The company is comprised of five directors. Significant regulatory non-compliance's were identified to the provider on previous inspections and as a consequence the Chief Inspector had renewed the registration of the centre in October 2024, with a reduced occupancy of 43 residents. Following some improvement in regulatory compliance found in January 2025, the Chief Inspector granted an application to increase the occupancy of the centre to 53 beds in July 2025. The registered provider used the additional ten beds for the purpose of providing a short-stay service, on the first floor of the designated centre. At the time of inspection, the short-stay service was no longer operational, and residents who were admitted to the first floor of the centre were receiving long term care. Prior to this inspection, the provider had submitted an application to renew the registration of the centre, with an application to increase the occupancy to 74 residents.

Changes had occurred to the regional management personnel since the previous inspection in September 2025, through the appointment of a chief governance, risk and compliance officer. A chief operations officer and a clinical director also participated in the management of the centre. Members of the regional management personnel were responsible for providing governance and support to the local management team. The person in charge was supported locally by an assistant director of nursing and a clinical nurse manager. Additional management support was provided by an operations manager. A team of nursing staff, health care assistants, housekeeping, catering, activity and made up the staffing compliment. There were deputising arrangements in place, in the absence of the person in charge.

The provider did not have the resources in place to ensure the effective delivery of care, in accordance with the centre's statement of purpose. At the time of inspection, a clinical nurse manager was on a period of extended leave and there was a vacant post for one full-time maintenance personnel. There was no arrangements in place to cover the clinical nurse manager vacancy while recruitment was in progress.

The staffing number and skill mix on the day of inspection, were not appropriate to meet the care needs of the residents. For example, inspectors observed several occasions where staffing levels did not allow for a timely response to residents' requests for assistance with their care needs and appropriate supervision of residents.

There were management systems in place to oversee the service and the quality of care, however, the systems in place did not ensure that the service provided was safe, appropriate, consistent or effectively monitored. For example, an internal review of regulatory compliance, which included an assessment of compliance with Regulation 21: Records, had been completed in January 2026 by a member of the senior management team. The completed review identified that records of fluids given to residents were not recorded accurately, and this was documented as a

significant risk. The review also identified a concern regarding oversight of the centre's electronic care record system and several recommendations were made in relation to this. However, the provider failed to effectively address this risk, and findings of non-compliance were repeated on this inspection, with regard to the accurate completion of nursing records.

Infection prevention and control audits were routinely undertaken. However, disparities between the findings of the most recent environmental audits, which achieved high levels of compliance, and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with Regulation 17: Premises.

There was a training programme in place for staff, which included mandatory training in fire safety, manual handling procedures, and safeguarding residents from abuse. While there were arrangements in place to induct and orientate staff, there were ineffective systems in place to ensure staff were appropriately supervised. For example, a number of staff were allocated to provide care to residents, who were not familiar with their specific care needs, such as the requirement for frequent continence care, in accordance with their care plan direction. Staff were not appropriately supervised to implement resident care plans, and maintain accurate records, which would evidence the care provided to residents. This is detailed further under Regulation 16: Training and development.

Record management systems consisted of both a paper-based and electronic system. Some records, required to be maintained in respect of Schedule 2, 3 and 4 of the regulations, were not appropriately maintained. Records pertaining to the nursing care provided to residents, and records of adverse incidents involving residents were not managed in line with the requirements of the regulations. For example, documentation and investigation of an incident in which a resident may have suffered potential abuse or harm was not completed in line with Schedule 3 (4)(j) of the regulations.

Regulation 15: Staffing

There was insufficient staff and skill mix to meet the assessed care needs of residents. For example:

- A resident who required continence and repositioning care was required to wait an extended period of time for care to be delivered.
- Inspectors observed that residents who required transfer from bed to chair, using assistive devices, had to wait extended periods of time for two staff to become available to assist them.
- A nurse and a carer were allocated to provide care to residents living on the first floor of the centre. Several residents living on the first floor required the assistance of two staff for their personal care needs. This meant that there

were occasions when staff were unavailable to supervise residents, as they were delivering personal care in resident bedrooms.

- There were occasions during the inspection where nursing staff were not present to supervise and direct care in one area of the centre.
- There was insufficient staff on a floor in the afternoon to respond to a resident who required urgent assistance. A care staff member was required to leave the floor unattended, to seek assistance from nursing staff working in another area of the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. This was evidenced by:

- Inadequate supervision of staff which meant that some residents' personal care plans were not being implemented, posing a risk to residents' health and well-being. Inspectors found this was in part due to lack of appropriate knowledge of the centres electronic care record system. In addition, staff demonstrated poor understanding of the centre's electronic care record system. This risk was compounded by ineffective supervision of newer staff members.
- Inspectors observed that one resident's bedroom was in an unhygienic state from early morning, and despite inspectors bringing this to the attention of management on several occasions, it was not addressed in a timely manner. The resident was served their lunch-time meal in their bedroom, before the bedroom was cleaned.
- Incorrect use of continence care products. Some products used did not align with residents continence assessments.
- Residents' care documentation was poorly maintained.

Judgment: Not compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Staff rosters were not maintained in line with the requirements of Schedule 4(9), and were not reflective of the actual roster worked by some management personnel.

- The provider did not ensure that all records relating to resident finances were kept in the designated centre.
- Records of nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of continence care and fluid intake and output were not maintained in line with the residents' care plan. This impacted on monitoring of residents with clinical risks.
- Some records of adverse incidents involving residents did not contain all the information required under Schedule 3(4)(j) of the regulations. For example, there was no results of investigations, learning, or action taken in response to three potential safeguarding incidents.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had failed to ensure that there were sufficient staffing resources in place to consistently maintain planned staffing levels, in line with the current resident care needs and the centre's statement of purpose. A clinical nurse manager was on extended leave, and records showed that there was a vacancy for one full-time maintenance person.

The management and oversight systems in place to ensure compliance with the regulations were not effective. This was evidenced by the following findings:

- The system in place to monitor incidents to ensure that residents were safeguarded from abuse were not effective. This meant that, where there was a potential safeguarding concern, this was not recognised as such, and therefore not managed in line with the national guidelines for safeguarding or the requirements of the regulations. This is a repeated finding.
- The systems in place to ensure oversight of staff supervision and allocation were not effective. Nursing and healthcare assistants were not appropriately supervised, and supported. Newly recruited staff were not allocated appropriately, having regard to the skill mix and the assessed needs of residents. The ineffective organisation of staff allocations and supervision impacted on the quality and safety of resident care. This is a repeated finding.
- A daily handover of pertinent resident information, such as infection status, was not provided to house-keeping and catering staff, in advance of cleaning resident accommodation areas, and serving meals and fluids.
- The registered provider had not ensured that all staff had adequate knowledge of the electronic care record system. This meant that staff were unable to record and access pertinent information relating to resident care. This is a repeated finding.

- Poor oversight of resident finances to ensure compliance with the regulations. For example, the management team were not familiar with the centre's own system for the management of resident finances.

An urgent compliance plan was requested to provide assurances that there were effective systems in place, to ensure oversight of staff supervision and allocation. This plan was accepted by the Chief Inspector.

Judgment: Not compliant

Quality and safety

This inspection found that the provider had failed to ensure that the assessed needs of residents were met, and that residents' rights were upheld in the centre. Furthermore, this inspection found that the measures in place to safe-guard residents living in the centre were not effective to ensure the a high standard of quality of life and safety of residents who lived in the centre.

The failings regarding assessment and care planning, the protection of residents and residents' rights, resulted in the provider being asked to submit an urgent compliance plan by 6 March 2026.

Inspectors found that the provider had addressed issues of non-compliance in relation to infection control found on the previous inspection in September 2025, however, the care environment was not fully aligned with requirements of the regulations.

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. An assessment of residents' health and social care needs was completed on admission to provide assurance that residents' individual care and support needs were identified and could be met. A sample of assessments and care plans were reviewed and found that, while each resident had a care plan in place, care plans were not always implemented effectively. For example, a resident with moisture-associated skin damage did not receive care in line with their plan of care. Furthermore, care plans were not reviewed following a change in the resident's condition. For example, inspectors identified two occasions where details of recommended wound dressings were not updated and used, following review by a tissue viability specialist.

Staff had completed up-to-date training in the prevention, detection and response to abuse, and procedures to safeguard residents were underpinned by a safeguarding policy that provided guidance and support to staff on the appropriate actions and measures to take to protect residents, should a safeguarding concern arise. However, inspectors found that the safeguarding policy and associated procedure had not been implemented in practice, and preliminary screening investigations

were not completed for several residents with unexplained injuries, to rule out any potential safeguarding concerns. This is a repeated finding.

Residents had access to local television, radio and newspapers. There was evidence of residents' meetings, which sought feedback on areas such as activities and the quality of food being served. Advocacy services were available to residents, and there was evidence that they were supported to avail of these services, as needed. Residents had access to religious services and resources and were supported to practice their religious faiths in the centre. However, inspectors found that residents' civil rights were not always promoted in the centre. Residents' rights to access information in relation to their finances was restricted, as records relating to resident finances, including financial statements, were held outside of the designated centre, and were not made available to residents.

Inspectors identified some examples of good practice in the prevention and control of infection. For example, staff applied standard precautions to protect against exposure to blood and body substances during handling of sharps and used linen. The provider had introduced a tagging system to identify equipment that had been cleaned, equipment was found to be generally clean on the day of the inspection. However, the laminate surface of dressing tables was damaged in several bedrooms. This may impact effective cleaning.

Improvements were evident in the detection and management of outbreaks. For example, a recent cluster of residents presenting with respiratory symptoms had been promptly identified and appropriate infection prevention and control measures and testing were implemented without delay, to contain and manage the potential outbreak effectively.

The outbreak of Carbapenemase-Producing Enterobacterales (CPE) colonisation was also ongoing at the time of the inspection. Staff had implemented all recommended infection prevention control measures to ensure the safety and well-being of residents, staff and visitors. No further cases had been detected since the outbreak was declared in June 2025, however, management confirmed that the outbreak would remain open for the foreseeable future to ensure there was no evidence of onward transmission within the centre.

The centre was observed to be generally clean, with some exceptions observed on the day of the inspection. For example, a spill of fluid was observed on the floor of one bedroom on arrival and was not addressed in a timely manner. In addition, the wall in one resident's bedroom remained visibly soiled throughout the morning of the inspection. These findings indicated delays in the prompt cleaning and removal of bodily fluids, and did not ensure that appropriate hygiene standards were consistently maintained.

In addition, one of the two external storage containers was observed to be unclean and cluttered. The container contained a large quantity of unused and broken equipment, and clothing belonging to deceased or discharged residents. In addition, supplies of alcohol hand gel were stored within the same space. Poor clinical waste

storage practices were also identified. Details of issues identified are set out under Regulation 17: Premises.

Residents had timely access to general practitioners (GP), specialist services and health and social care professionals such as physiotherapy, dietitian and speech and language therapy, as required.

Procedures were in place to ensure that the transfer of residents from the designated centre occurred in line with the requirements of the regulations. This included consultation with residents and their representatives regarding transfers and discharges, and arrangements to ensure information pertinent to the care of residents were communicated to the receiving health care facility.

Visitors were observed attending the centre throughout the day of the inspection. Inspectors saw that residents could receive visitors in their bedrooms or in a number of communal rooms.

Regulation 11: Visits

Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors, as they wished.

Judgment: Compliant

Regulation 17: Premises

The registered provider failed to ensure that the premises conformed to the matters set out in Schedule 6 of the regulations. For example:

- Damp and water damage remained on the walls in Holly unit. Peeling paint and damp surfaces increased the risk of mould, dust and microorganisms. While a survey had been undertaken and recommendations had been made, there was no time bound action plan in place to address the issue.
- There was no system in place to ensure the timely cleaning of bodily fluids and the consistent maintenance of appropriate hygiene standards within the centre.
- The laminate surface was observed to be peeling away from dressing tables in several resident bedrooms which meant that these surfaces could not be effectively cleaned.
- There was no bedpan washer on the first floor sluice, which meant staff were required to bring utensils to the ground floor sluice room for decontamination. This increased the risk of environmental contamination and the spread of MDRO colonisation.

- External healthcare-risk waste wheeled-bins were not stored securely from interference by unauthorised persons. For example; two bins (containing healthcare risk waste) were unlocked and a bag of risk waste was observed on top of one bin.
- The infrastructure of the on-site laundry remained unchanged and did not support the functional separation of the clean and dirty phases of the laundering process.
- The overall condition of one of the external storage containers was untidy and poorly organised.
- When activated, the location of a falls alert device displayed in one area of the centre only. This may pose a delay in attending to the safety needs of residents promptly.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

A review of documentation found that when residents were transferred to hospital from the designated centre, relevant information was provided to the receiving hospital. Copies of transfer documents were maintained on residents electronic files. Upon residents' return to the designated centre, staff ensured that all relevant clinical information was obtained from the discharging service or hospital.

Judgment: Compliant

Regulation 27: Infection control

Inspectors identified some examples of good practice in the prevention and control of infection. On the day of the inspection, staff were observed to apply basic infection prevention and control measures known as standard precautions to minimise risk to residents, visitors and their co-workers, such as hand hygiene, appropriate use of personal protective equipment, and safe handling and disposal of sharps and used linen.

Overall improvements were also noted in outbreak detection and management. Two recent suspected respiratory outbreaks had been detected, managed, controlled and reported in a timely and effective manner.

Findings relating to premises, environmental hygiene, maintenance, waste management and storage are addressed under Regulation 17: Premises.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of residents' individual assessments and care plans found that the registered provider did not ensure that the assessed needs were met. For example:

- Two residents who were assessed as being at high risk of pressure related injuries, did not have appropriate pressure relieving mattresses in place.
- A resident who had moisture associated skin damage, did not receive care in line with their plan of care.
- A resident who had a deteriorating pressure related wound had not been reassessed to establish if an alternative treatment was required, in line with their plan of care
- A care plan that directed increased monitoring of a resident's output, due to a known underlying medical condition, had not been implemented.

Inspectors identified two occasions where details of recommended wound dressings were not updated and used following review by the tissue viability specialist.

An urgent compliance plan was requested to provide assurances that the registered provider shall arrange to meet the needs of each resident living in the centre.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to medical care, and records demonstrated that referral systems were in place for residents to access allied health and social care professionals, such as dietitians, tissue viability specialists, and speech and language therapists, for additional support and expertise. A physiotherapist attended the centre.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that the registered provider failed to take reasonable measures, to protect residents from abuse in the centre. For example;

- Preliminary screening investigations were not undertaken in relation to three residents who had sustained unexplained injuries, in line with the centre's

own safeguarding policy. This is a repeated finding from two previous inspections.

- A garda vetting disclosure was not available for some individuals were spending time alone with residents, while providing a service.

An urgent compliance plan was requested to provide assurances that the registered provider shall take all reasonable measures to safeguard residents from abuse, and ensure the consistent implementation of safeguarding policies and procedures.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors found that resident concerns were recorded, and resident meetings were held, however, issues raised at these meetings had not been effectively addressed, such as concerns regarding communication with staff and staffing levels.

The provider did not ensure that residents' civil rights were consistently upheld. For example:

- Statements of residents' accounts were not routinely issued. This limited residents ability to retain control over their finances, as they could not monitor their own accounts and financial transactions.

The provider had not ensured that residents could carry out activities in private. For example:

- Close circuit television (CCTV) was in place throughout the centre, along corridors and in resident communal dining and sitting rooms. However, there was limited signage displayed, to advise residents and visitors that this monitoring system was in place.

Inspectors observed that one resident had restricted choices in relation to an aspect of their daily routine.

Inspectors observed that one resident had restricted choice in relation to their night-time routine, due to an ongoing concern which had not been addressed.

Judgment: Not 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	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for An Teaghlach Uilinn Nursing Home OSV-0000309

Inspection ID: MON-0049401

Date of inspection: 02/03/2026

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: An immediate review of staffing dependency, floor allocations and peak demand periods has been completed. Rosters and daily allocations have been adjusted to better align staffing with resident needs, particularly in areas where a higher number of residents require two-person assistance for personal care and transfers. Nursing allocations have also been revised to support consistent clinical supervision across all areas. On the top floor, which accommodates 10 residents, where an individual require the assistance of two staff for personal care, supervision will be maintained by the supernumerary ADON and/or CNM during these periods, ensuring oversight is not compromised while care is being delivered in residents' bedrooms. Residents who require frequent repositioning, continence care or two-person assistance are identified at handover and within daily allocation sheets to support prioritisation of care and reduce delays. Escalation arrangements have been clarified so staff can seek support promptly when required. The PIC complete daily walk-rounds, including review of call-bell response times, with any issues addressed at the time. Staffing levels, response times and any incidents relating to delayed care are reviewed weekly by the management team and are also highlighted with the care team during daily safety pauses. Recruitment to vacant posts is ongoing. In the interim, the roster has been revised to support management presence and supervision. Pending recruitment of a second CNM, the ADON and CNM are rostered opposite each other across seven days, ensuring management cover is in place daily and that both morning and evening handovers are attended. In addition, a member of the head office clinical team is onsite Monday to Friday to provide support and oversight to staff and with an on-call arrangement in place at weekends to provide guidance and input as required.	

These arrangements will be kept under review, with further adjustments made where necessary to ensure staffing levels and skill mix continue to reflect residents' assessed needs.

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Regulation 16: Training and staff development

Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Immediate actions were taken to address the issues identified.

All staff have received refresher training and on-the-floor support continues from the Operations Manager in the use of the electronic care record system. New staff are not allocated duties independently until their competency in care delivery and documentation systems has been confirmed by the ADON/CNM.

The centre's induction process has been reviewed, number of days extended and strengthened. The revised induction outlines required competencies, the responsibilities of the new staff member and their allocated mentor and includes defined timelines for progression. New staff are required to complete all mandatory training and provide the necessary compliance documentation prior to commencing duty. Newly recruited staff are not permitted to provide care independently until they have completed their theory induction and a period of supervised on the floor practice, with competency confirmed by the ADON/CNM.

Supervision arrangements have been revised. Pending recruitment of a second CNM, management hours have been adjusted to ensure the ADON and CNM provide on-site supervision across seven days. This includes attendance at daily handovers, safety pauses and walk-rounds, with oversight of care delivery, staff practice and response times. Supervision of newer staff is prioritised to ensure appropriate guidance and oversight.

In relation to environmental hygiene, responsibility for bedroom checks has been allocated on each shift to each HCA. Any issues identified are addressed immediately and escalated to the nurse in charge. This is monitored through daily walk-rounds by the ADON / CNM.

Continence care practices have been reviewed. Residents' continence assessments have been checked and products in use aligned with assessed needs. Staff are required to follow these assessments, and compliance is monitored by the nurse in charge.

Care documentation has been reviewed and corrected where required. Ongoing oversight

is in place through regular audit of care records, with any issues addressed with staff. These measures are reviewed through daily safety pauses, walkabouts, weekly meetings and weekly management review to ensure supervision is maintained and care is delivered in line with residents' assessed needs.

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Regulation 21: Records

Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records: Staff rosters have been reviewed and are now maintained in line with Schedule 4 requirements. Rosters accurately reflect the staff on duty, including management presence, and are reviewed weekly by the Head Office Team and the Operations Manager to ensure accuracy.

All records relating to residents' finances have been reviewed. These records are now maintained within the designated centre in line with regulatory requirements, with oversight in place by the Operations Manager to ensure they remain accessible and up to date from the Head Office Finance Team.

In relation to nursing documentation, care records have been reviewed and corrected where required. Staff have been reminded of the requirement to maintain accurate and contemporaneous records in line with residents' care plans. Particular focus has been placed on continence care and fluid balance monitoring to ensure clinical risks are appropriately recorded and monitored. Compliance is monitored through regular audit of care records by the nurse in charge and management team.

Records of adverse incidents have been reviewed. All incidents are now required to include details of the investigation, outcome, learning identified and actions taken, either within the incident form or as uploaded supporting documentation. The PIC reviews all incidents to ensure records are complete and that appropriate follow-up actions are documented and implemented. This process is further overseen by the Chief Governance and Risk Officer at Head Office.

Ongoing oversight of record-keeping has been strengthened. Daily sample checks of care records are completed by the management team in conjunction with the nurse in charge as part of the daily safety pause. In addition, the PIC/ADON completes independent spot checks of records each day. Findings are addressed with the staff member responsible at the time, and where gaps are identified, the reason is established and addressed. Where this relates to a knowledge or competency issue, this is followed up with targeted guidance and support.

These measures are supported by ongoing audit and management oversight to ensure

records are accurate, complete and maintained in line with regulatory requirements.

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Regulation 23: Governance and management

Not Compliant

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

An immediate review of staffing dependency, floor allocations and peak demand periods has been completed. Rosters and daily staff allocations have been revised to ensure that staffing levels are aligned with resident needs. Nursing allocations have also been adjusted to ensure consistent clinical supervision across all areas.

Recruitment to vacant posts is ongoing. Pending the recruitment of a second CNM, the ADON and CNM are rostered opposite each other across seven days, ensuring daily management cover and attendance at both morning and evening handovers.

In addition, a member of the head office clinical team is onsite Monday to Friday to provide additional support and oversight to staff, with an on-call arrangement in place at weekends to provide guidance and input as required. These arrangements are subject to ongoing review, with further adjustments made as required to ensure that staffing levels and skill mix continue to reflect residents' assessed needs.

The full-time maintenance has been filled and the staff member commenced induction on March 03rd.

In relation to safeguarding and incident management, the provider has strengthened systems to ensure all incidents are appropriately identified, reviewed and managed. All unexplained injuries have been retrospectively reviewed, and safeguarding screening assessments have been completed in line with policy. Moving forward, all incidents are subject to immediate review by the PIC/ADON, with daily oversight, weekly KPI monitoring and monthly audits to ensure that potential safeguarding concerns are promptly recognised and managed in line with national guidelines. This process is further overseen on a weekly basis by the Chief Governance and Risk Officer to ensure effective governance and sustained compliance. Further detail is outlined under Regulation 8 below.

In relation to staff supervision and allocation, a comprehensive review has been undertaken. Enhanced supervision arrangements are now in place, including daily review of staff allocation, increased management oversight, and regular walkarounds. Newly recruited staff are now supported through a structured induction programme and are not rostered on the floor until deemed competent. Staff allocation is being managed to ensure appropriate skill mix and support is available at all times. These measures are

supported by ongoing safety pause meetings and monitoring of care delivery to ensure sustained improvement. Further detail is outlined under Regulation 16.

In relation to communication systems, processes have been strengthened to ensure that all relevant resident information, including infection status, is communicated effectively across departments. Daily handover processes have been reinforced to ensure housekeeping and catering staff receive pertinent information in advance of delivering services, supporting safe infection prevention and control practices.

In relation to the electronic care record system, additional training and support has been provided to all staff. Refresher training sessions have been arranged, and staff competency is being supported through supervision, safety pause meetings and ongoing monitoring by the PIC and ADON to ensure staff can effectively record and access resident care information.

In relation to the management of residents' finances, a full review of financial management systems has been completed to ensure compliance with Department of Social Protection guidelines. Systems have been strengthened to ensure all transactions are clearly recorded, traceable and linked to individual residents. Monthly statements will be issued to residents, and oversight has been enhanced through management review and audit processes to ensure transparency and accountability.

Overall governance and oversight arrangements have been strengthened through the introduction of regular audits, KPI monitoring, daily and weekly management reviews, and increased involvement of senior management, including the Clinical Director and Chief Governance, Risk and Compliance Officer, to ensure that systems are effective, monitored and sustained.

These actions are detailed further under each relevant regulation within the compliance plan.

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Regulation 17: Premises

Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider acknowledges the concerns identified regarding dampness and water damage within the Holly Unit.

A Civil Engineer on-site assessment has now been confirmed for 16th May 2026. This assessment will include a detailed review of all affected areas to identify the extent and underlying cause of the dampness and water ingress issues.

Following completion of this assessment, the provider commits to submitting a

comprehensive and time-bound action plan outlining:

- The specific remedial works required;
- Timeframes for commencement and completion of works;
- Responsible persons/contractors assigned to each action;
- Measures to ensure the affected areas are restored to a standard that supports effective cleaning, maintenance, infection prevention and control, and ongoing compliance with Regulation 17.

The provider will ensure that all identified remedial works, including repair of damaged surfaces and repainting where required, are completed within agreed timelines and subject to ongoing oversight and review.

Arrangements for the cleaning of bodily fluids have been clarified with the use of spill kits. Staff have been instructed on their responsibilities to ensure immediate cleaning and decontamination when required. This is overseen by the nurse in charge and monitored through daily walk-rounds and safety pauses.

Damaged furniture, including dressing tables with peeling laminate surfaces, has been identified. These items are being repaired or replaced to ensure all surfaces are intact and can be effectively cleaned.

The provider acknowledges the concerns identified regarding the absence of a bedpan washer/sluice facility on the first floor.

Interim control measures have been implemented to support the safe transport and decontamination of equipment pending establishment of a permanent solution. Covered bedpans with secure lids have been purchased and are in use to ensure contaminated materials are safely contained prior to transport. In addition, all items are transported in sealed bags directly to the ground floor sluice room for decontamination. A risk assessment has been completed to ensure this interim process is carried out safely and consistently, with appropriate infection prevention and control measures, staff guidance, and oversight in place to minimise the risk of environmental contamination and cross infection pending confirmation of the long-term solution.

The provider has completed a review of the layout and available facilities on the upstairs floor. Accordingly, the provider intends to submit an application to vary the conditions of registration to allow for the change of function of an existing store room on the top floor into a dedicated sluice/dirty utility facility incorporating a bedpan washer.

Subject to approval, the room will be converted and equipped to ensure appropriate decontamination processes can be carried out safely and effectively on the first floor.

The provider will ensure that all required infection prevention and control measures, environmental controls, and equipment requirements are incorporated into the proposed redevelopment to support compliance with Regulation 27 and Regulation 17 and to reduce the risk of cross contamination for residents and staff.

External healthcare risk waste storage has been addressed. All bins are now locked when not in use, and staff have been instructed on correct waste management practices. This is monitored by the management team.

The provider acknowledges the finding in relation to the layout and infrastructure of the on-site laundry and the importance of ensuring effective separation of clean and dirty phases in line with infection prevention and control standards.

The provider had initially considered the installation of an external laundry unit; however, having reviewed the associated planning permission requirements and potential delays, an alternative review of the existing laundry layout has now been agreed to support a more immediate solution.

A reconfiguration of the current laundry area will be undertaken to ensure clear segregation between clean and dirty processes. This will involve:

- Removal of all non-essential items currently stored within the laundry;
- Reorganisation and relocation of laundry equipment;
- Repositioning of shelving and storage arrangements;
- Establishment of clearly defined clean and dirty workflow areas within the room.

These works are intended to improve workflow management, reduce the risk of cross contamination, and ensure compliance with infection prevention and control requirements relating to laundry management.

The provider confirms that these works are scheduled to commence 19th May 2026 and are expected to be completed within two days. Oversight of the revised layout and processes will be maintained to ensure the effectiveness of the new arrangements and ongoing compliance with regulatory standards.

External storage areas have been organised and cleared to ensure they are maintained in a clean and orderly condition. Ongoing checks are completed by the management team.

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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:

In relation to pressure area care, the two residents identified as being at high risk of pressure-related injury were provided with appropriate pressure-relieving mattresses. All residents identified as being at risk were reviewed to ensure appropriate pressure-relieving equipment is in place, and additional equipment has been sourced to ensure adequate availability within the centre. A weekly review of pressure-relieving equipment is now in place to ensure ongoing compliance.

In relation to wound management, the resident identified with a deteriorating pressure-

related wound was escalated immediately. The Tissue Viability Nurse was contacted, and the wound has been reassessed, with care plans updated to reflect current treatment. A review of all residents with wounds was completed on 05 March 2026 by the Clinical Director to ensure that wound management practices and dressing regimes are in line with current recommendations. Where discrepancies were identified between prescribed treatments and those in use, these were corrected and care plans updated accordingly.

In relation to continence care and skin integrity, a continence wear audit was completed on 05 March 2026. Where assessments were not aligned with residents' needs, these were repeated and appropriate products implemented. Care plans have been updated to reflect residents' current requirements, and staff are required to follow these plans. In addition, this is reflected on the handover information document.

For residents requiring monitoring of fluid intake and output, this has been reinstated in line with care plans and medical direction. Nursing staff are required to complete these records, and this is overseen by the supernumerary management team member each day.

Enhanced monitoring has been implemented. Nursing staff complete reviews of care delivery and associated documentation, including repositioning, continence care and fluid balance records, with oversight from the PIC and ADON. Any gaps identified are addressed at the time with the staff member involved.

The PIC, ADON and Clinical Director provide direct oversight to staff on the floor, reinforcing requirements in relation to pressure area prevention, wound management, continence care and accurate documentation. A clear escalation pathway has been reinforced to ensure that any deterioration in a resident's condition is reassessed and escalated promptly to the Person in Charge, GP and Tissue Viability Nurse where required.

Key indicators relating to wound care, pressure area prevention and clinical documentation are reviewed weekly by the Clinical Director and Chief Governance and Risk Officer, with actions identified tracked and monitored through the centre's governance processes.

Overall responsibility for implementation and ongoing oversight rests with the Person in Charge, supported by the ADON and CNM, with monitoring through the centre's governance and quality assurance systems.

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Regulation 8: Protection

Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

Following the inspection, the three incidents relating to unexplained injuries were reviewed by the Person in Charge, and safeguarding screening assessments have now been completed in line with the centre's Safeguarding Policy and Procedures. These incidents have been assessed, documented and managed in accordance with safeguarding requirements, including risk assessment and appropriate follow-up actions.

The requirement to complete preliminary screening for all unexplained injuries has been reinforced with the nursing management team by the Chief Governance, Risk and Compliance Officer. Staff have been directed that all such incidents must be reviewed immediately, documented appropriately and screened for potential safeguarding concerns, with submission of an NF06 notification where required. This has been reinforced with staff through safety pause meetings following the inspection and was further addressed at a scheduled nursing team meeting on 09 March 2026.

Oversight arrangements have been strengthened. All incidents are now reviewed daily by the PIC/ADON to ensure that any potential safeguarding concerns are identified and acted upon promptly. Safeguarding incidents and unexplained injuries are also reviewed as part of weekly governance meetings with the Clinical Director and Chief Governance and Risk Officer, using the centre's KPI monitoring tool to ensure appropriate oversight and follow-up.

In addition, the PIC completes monthly audits of incident reports and safeguarding documentation to ensure that all unexplained injuries are appropriately screened and managed in line with the centre's safeguarding procedures.

In relation to Garda vetting, the provider acknowledges that appropriate documentation was not available for an individual providing services within the centre. Immediate action has been taken to ensure that no individual is permitted to provide services within the centre without the required documentation, including Garda vetting disclosure, a contract for services and appropriate identification.

A review of all external service providers accessing the centre has been undertaken by the Operations Manager to ensure that appropriate vetting, contractual agreements and identification records are in place.

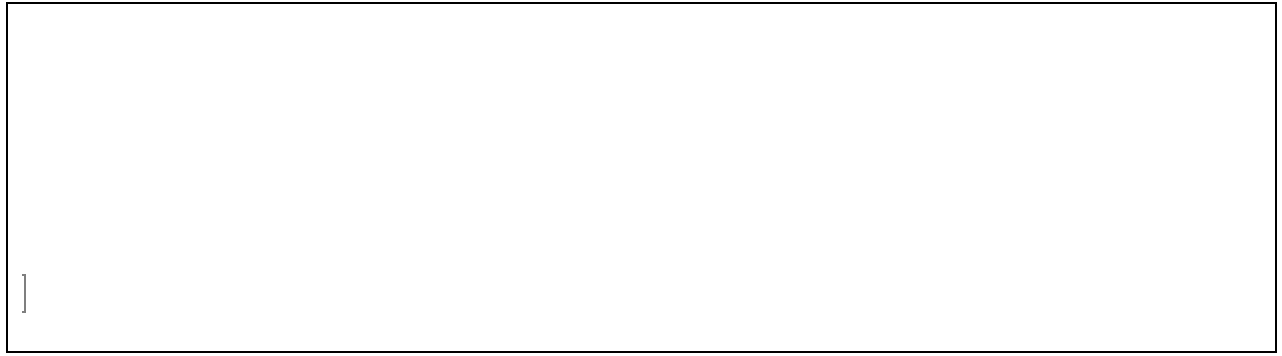
A central register of external contractors and service providers will be maintained by the Operations Manager to ensure that all required documentation is verified and available prior to individuals' providing services within the centre.

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Regulation 9: Residents' rights

Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Following the inspection, a review of resident meetings and feedback mechanisms has been completed. Actions arising from resident meetings are recorded, assigned and tracked to completion by the management team to ensure that issues raised, including those relating to communication and staffing, are addressed. Feedback on actions taken is provided to residents at subsequent meetings. In relation to residents' finances, the accounting process has been reviewed and updated to ensure that all transactions relating to residents' funds are clearly documented and traceable, including invoices and payments made on behalf of individual residents. Systems are being implemented to ensure that individual resident accounts accurately reflect all income and expenditure, and that appropriate records are maintained for each resident. Residents will be provided with monthly statements outlining funds held and transactions completed on their behalf, in line with best practice and regulatory expectations. The registered provider has completed a risk assessment regarding the use of CCTV within the centre to ensure residents' privacy, dignity, and rights are upheld at all times. Residents have been informed about CCTV usage during residents' meetings and ongoing discussions within the centre. Signage is displayed throughout the building to clearly inform residents, visitors, and staff of the presence and purpose of CCTV systems. To further strengthen governance and transparency: • Consent forms relating to CCTV usage will be requested from residents and/or their next of kin. • A CCTV Camera Justification Log will be completed by 22 May 2026, detailing the location of every camera, the rationale for its use, and confirmation that each placement has been reviewed in line with residents' privacy rights. • The provider will continue to ensure residents are regularly informed and consulted regarding CCTV usage within the centre. The provider confirms that CCTV is not installed in residents' bedrooms, bathrooms, or any area used for intimate personal care. Where residents wish to hold meetings, visits, or private conversations, private areas are made available that are not subject to CCTV. Residents' choices and preferences in relation to their daily routines have been reviewed. The specific concerns identified during the inspection have been addressed with the residents involved, and care plans have been updated to reflect individual preferences, including night-time routines. Staff have been instructed to support residents' choices and promote autonomy in daily living. Supervision and oversight by the management team have been strengthened to ensure that residents' rights, dignity and choice are respected in practice. This includes ongoing review of care delivery, resident feedback and daily engagement with residents to ensure their preferences are upheld.	



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	30/07/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	05/05/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	15/08/2026
Regulation 21(1)	The registered provider shall	Not Compliant	Orange	30/05/2026

	ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/05/2026
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	Red	05/03/2026
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	Red	05/03/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4	Not Compliant	Orange	30/05/2026

	months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	06/03/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	22/04/2026
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	06/03/2026
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	Substantially Compliant	Yellow	30/04/2026

	designated centre concerned.			
Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Not Compliant	Orange	06/03/2026