



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

Issued by the Chief Inspector

Name of designated centre:	West Clare Nursing Home St Theresa's Kilrush
Name of provider:	Sundyp Limited
Address of centre:	Leadmore East, Kilkee Road, Kilrush, Clare
Type of inspection:	Unannounced
Date of inspection:	03 March 2026
Centre ID:	OSV-0000451
Fieldwork ID:	MON-0049615

About the designated centre

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

St. Theresa's Nursing Home is a purpose built single-storey facility which can accommodate up to 39 residents. It is located close to the town of Kilrush. It accommodates both male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older persons who require general nursing care, respite, convalescence, palliative and dementia care. Bedroom accommodation is provided in 24 single bedrooms, six twin bedrooms and a three bedded room. All of the bedrooms have en suite toilet and shower facilities, except one which has direct access to its own dedicated shower/toilet room. There is a variety of communal day spaces including day room, dining room, sun rooms, smoking room, oratory and front reception area. Residents also have access to secure enclosed garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39
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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
Tuesday 3 March 2026	10:05hrs to 19:00hrs	Sean Ryan	Lead
Tuesday 3 March 2026	10:05hrs to 19:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

Residents living in this centre reported satisfaction with the quality of care provided to them. Residents described staff as familiar, and consistent in the support they provided to them, which they said contributed to them feeling safe and comfortable in the centre. Residents also spoke positively about the activities provided, and said that they enjoyed the opportunities available to them each day, allowing them to remain engaged and socially active.

Inspectors arrived at the centre unannounced and were met by the person in charge. Following brief introductions, inspectors completed an initial walk-through of the centre. During this time, inspectors observed the premises and care environment, engaged with staff and residents, and observed interactions between staff and residents throughout the centre.

There was a busy atmosphere within the centre on the day of the inspection as works were progressing as part of a programme of fire safety improvement works. Contractors were present in parts of the centre during the inspection. Some residents were observed spending time in communal areas, receiving visitors, while others were relaxing in the privacy of their bedrooms. Staff were observed to make regular checks on residents who chose to remain in their bedrooms, and were heard asking residents if they were comfortable and if they required assistance while in their bedrooms.

Inspectors met with the majority of residents and spoke with a number of residents in detail about their experience of living in the centre. Residents described the centre as a "home from home" and said that they felt comfortable and well supported in their daily lives. Residents spoke positively about staff and described them as attentive to their needs. Residents said that staff supported them with activities of daily living, including personal care and assistance with dressing and organising their personal space. Residents reported that they enjoyed their daily routines within the centre, and commented that the positive personalities of some staff made living in the centre an enjoyable and positive experience.

Residents said they 'never felt like they were asking too much' when requesting assistance and that staff reassured them that they were there to assist them. Residents described staff spending time chatting with them and encouraging them to spend time in communal areas and participate in activities with other residents. Residents also said that they were treated with respect and dignity and that staff recognised them as individuals. They reported that the management team were kind, supportive and approachable, and that their choices and preferences, including decisions relating to their health care, were respected.

The centre provided a mix of single and multi-occupancy bedroom accommodation. Residents expressed satisfaction with their bedrooms and the accommodation

provided to them. Bedrooms had the required storage and facilities to enable residents to store their personal belongings. Inspectors observed that, equipment such as hoists and mobility aids were being stored in one triple-occupancy bedroom, which reduced the available space for residents.

Overall, the physical environment was observed to be clean and well-maintained, with the exception of some en-suites and communal bathroom facilities. In these areas, equipment used to support residents with their toileting needs were found to be inappropriately stored and visibly unclean. Inspectors also observed that some residents' personal products were being stored in a communal bathroom cupboard.

During the walk-through of the centre, some fire safety risks were observed, including fire doors being held open, and gaps present in some fire doors. There were inadequate fire management measures in the smoking, including fire-fighting equipment and a call bell. Additionally, chairs were stacked and stored near fire exits, potentially obstructing evacuation routes. It was acknowledged that the provider was undertaking a significant programme of remedial works at the time of inspection, which included the replacement and upgrading of bedroom and fire doors, as part of wider fire safety improvement works.

Inspectors observed the tea-time dining experience for residents. A menu was displayed for residents and operated on a two-week rotating cycle. Catering staff, together with a health care assistant, were present in the dining room to support residents during the meal service. Residents spoke positively about the quality and flavour of the food provided. However, inspectors observed that the supervision of some residents during the meal service was limited, particularly for some residents who required additional support or encouragement with their meals. At times, the staff member supporting residents in the dining room was required to leave the area to assist other residents who had finished their meal, which reduced supervision available to those who remained at the table. During these periods, some residents were observed not eating their meals. Inspectors also observed that not all residents were consistently offered a choice at mealtime.

Residents were actively engaged in a variety of activities through the day of inspection. In the morning, residents participated in a celebration of Mass. Some residents chose to spend time in quieter spaces enjoying their own company. In the afternoon, residents took part in a quiz which was facilitated by a dedicated activities staff member. While there was a staff member responsible for coordinating activities, all staff were observed engaging with residents and supporting their participation.

Information about the services available to residents was accessible within the centre. A notice board displayed information relevant to residents, including details of advocacy services, safeguarding information and activities available within the centre. Residents told inspectors that they were familiar with how to raise any concerns or dissatisfaction about the service and said they would not hesitate to do so if required.

Visiting arrangements were flexible and facilitated throughout the day. Visitors were observed attending the centre during the inspection and were seen spending time with residents in communal areas.

The following sections of this report detail the findings with regard to the capacity and capability of the provider and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This unannounced inspection was carried out 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), with a particular focus on fire safety and premises. Inspectors also followed up on the actions taken by the provider to address issues of non-compliance found on the last inspection in February 2025.

This inspection identified a number of actions taken by the provider to enhance aspects of the service. At the time of this inspection, the provider was progressing a programme of works to enhance fire safety arrangements within the centre. The provider had also taken action following the previous inspection to ensure that complaints were managed in line with the requirements of the regulations and that residents' rights were supported through the provision of consistent activities. However, this inspection found that, while the centre had a sufficiently resourced nurse management structure in place, the roles, responsibilities and lines of accountability within this structure were not clearly defined. This impacted on effective monitoring and oversight of key aspects of the service that included the monitoring of care delivery, nursing documentation, infection prevention and control practices and fire safety. Furthermore, inspectors found that the oversight systems in place to ensure effective monitoring of residents' nutritional care needs and nutritional risks were not effective. As a consequence of these concerns, an urgent compliance plan was issued to the provider following the inspection. The providers response to the urgent compliance plan request provided assurance that the risks identified had been adequately addressed.

Sundyp Limited is the registered provider of this centre. A director of the company represented the provider in engagement with the Chief Inspector and also held the role of person in charge.

The management structure within the centre comprised the person in charge, an assistant director of nursing, two clinical nurse managers and one acting clinical nurse manager. Inspectors found that the management structure was not clearly defined, and clear lines of authority and accountability were not fully established. The management arrangements in place did not clearly allocate responsibility for the clinical oversight and monitoring of key aspects of the service. Consequently, it was

not always clear who held responsibility for the oversight of systems such as records management, nursing documentation and care planning, infection prevention and control practices, and the monitoring of residents' nutritional care. This lack of oversight meant that some risks within the service were not identified through the centre's monitoring arrangements. For example, inspectors found that a significant number of residents had experienced weight loss since January 2026. However, the governance systems in place had not identified sustained weight loss in residents, had not ensured that appropriate interventions were implemented, or reviewed or that residents were appropriately referred for further expert assessment.

The centre maintained records using a combination of electronic and paper-based systems. At the time of this inspection, the provider was progressing a staged implementation of an electronic record system to support the management of nursing and medical records. Inspectors also reviewed a sample of staff personnel files and found that these were maintained in line with the requirements of Schedule 2 of the regulations. However, some records were not maintained in line with the requirements of the regulations. For example, records relating to the care and monitoring of residents were not consistently maintained, or managed in a manner that ensured they were readily accessible. In addition, some records requested during the inspection were not made available to inspectors in a timely manner, and others were not provided for review during the inspection.

The management systems in place to recognise and respond to complaints ensured that complaints and concerns were acted upon in a timely, supportive and effective manner. Complaints were recorded in the centre's complaints register and records evidenced that complaints were being acknowledged, investigated or resolved to the satisfaction of the complainant.

There were sufficient staffing resources in place, with an appropriate skill-mix of staff to meet the assessed needs of residents. The staffing arrangements in place supported continuity of care for residents. Rosters reviewed indicated that staffing levels and skill-mix were planned and allocated in a manner that supported the delivery of care and services to residents. Staff providing direct care to residents were observed to be familiar with residents' individual needs and preferences, and responded to residents in a manner that reflect this knowledge.

Staff were facilitated to attend training to support them in their roles. This included training in areas such as safeguarding of vulnerable people, fire safety, infection prevention and control, and dementia awareness. Staff spoken with during the inspection demonstrated an awareness of safeguarding practices and their role in protecting residents from abuse. Staff also displayed knowledge of fire safety procedures and fire prevention measures.

Staff supervision arrangements were in place, and members of the nurse management team were present in the centre and involved in the day-to-day supervision of the service. However, inspectors found that these supervision arrangements were not fully effective. This was evidenced by deficits identified in the delivery and monitoring of residents' nutritional care, clinical monitoring of

residents in line with their care plans, the maintenance of records, and the consistent implementation of infection prevention and control practises.

Regulation 15: Staffing

On the day of the inspection, the staffing level and skill mix were appropriate to meet the needs of residents in line with the centre's statement of purpose.

There was sufficient nursing staff on duty, and they were supported by a team of health care staff. The staffing compliment also included catering, housekeeping, administrative and management staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not fully effective to protect and promote the care and welfare of residents. This was evidenced by ineffective supervision of;

- resident's clinical documentation to ensure that resident's assessments and care plans were an accurate reflection of the residents care needs.
- the delivery of care in line with residents care plans and the recommendations of allied health care professionals.
- nursing care records, including records of referrals to medical professionals and medical reviews, to ensure they were appropriately maintained.

Judgment: Substantially 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;

- Records of on-going medical assessment, treatment and care were not consistently maintained, as required by Schedule 3(4)(e) of the regulations. For example, a record of a resident's medical reviews was not always maintained in the centre, or available to staff for review.
- Records of specialist treatment, nutritional care and nursing care provided to residents were not appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records pertaining to the nutritional care and

monitoring of residents was not appropriately maintained or not available for review.

Records required under Schedule 3 and 4 of the regulations were not readily accessible and were not provided for review during the inspection. This included records of the maintenance and testing of the fire alarm and emergency lighting systems

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure did not clearly define lines of authority and accountability for the oversight and monitoring of key clinical and environmental areas of the service. Responsibilities for aspects such as infection control, fire safety, record management and care practices were unclear, particularly in relation to the oversight of nutritional risk. In addition, the oversight of these aspects of the service were not clearly allocated to members of the nurse management team, which impacted effective monitoring of quality and safety and resulted in potential risks to residents not being identified and escalated to senior management.

The management systems in place to ensure oversight of residents' nutritional care were not effective. As a result, the management team had not identified residents with sustained weight-loss, and did not ensure appropriate interventions were implemented or reviewed following further specialist review. Due to the level of risk identified, an urgent compliance plan was requested from the provider following the inspection. The Chief Inspector accepted the assurances that the identified risks had been addressed within this place.

In addition, the systems of monitoring in place for record management, staff supervision, fire safety, infection control and clinical care records were not fully effective. While audits were in place in relation to these aspects of the service, they were not effective to identify issues in practice. Consequently, those systems had not identified that these aspects of the service were not in full compliance with the requirements of the regulations.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was a complaints policy in place and this was updated in line with regulatory requirements. Records of complaints were maintained in the centre and the

inspector found that these were acknowledged and investigated promptly and documented whether or not the complainant was satisfied.

Judgment: Compliant

Quality and safety

Residents reported enjoying a good quality of life in this centre. The residents' quality of life was enhanced by a team of staff who cared for them in a respectful and person-centred manner, and who knew their personal care needs and preferences. Social care was observed to be delivered to a high standard. While the standard of health care delivery was observed to be satisfactory, the oversight of this care was ineffective, as described in the capacity and capability section of this report. This was particularly evident in the management of nutritional risk and infection prevention and control, where the monitoring of this care was inadequate, and care plans were found to be poorly detailed and not updated to reflect residents' changing needs. In addition, some aspects of the premises, infection control and fire safety management, including the containment and management of fire, did not ensure full compliance with the regulations.

A review of the nutritional aspects of the service found that the provider did not have robust arrangements in place to identify clinical nutritional risk and monitor the nutritional care needs of residents. While nutritional screening was in place for all residents, the dietary needs of each resident, as prescribed and planned, was not met. Arrangements were not in place to appropriately monitor a number of residents who had lost weight in the centre. Inspectors found that residents who had been assessed by health care professionals as requiring therapeutic diets, including high-protein and high-calorie diets to manage their weight, were not receiving diets in line with these recommendations. As a consequence of these concerns, an urgent compliance plan request was issued to the provider following this inspection.

Residents were supported to access a general practitioner (GP) of their choice and were facilitated to retain their own GP if they wished. Residents had access to GP services as required or upon request. Arrangements were also in place to refer residents to other health care professionals for further specialist assessment and treatment when clinically indicated; however, as described above, these recommendations were not always implemented.

A sample of residents' assessments and care plans were reviewed. Some care plans were not based on a comprehensive assessment of residents' needs, were not consistently updated following changes in residents' conditions, or did not provide clear, person-centred guidance to staff on how to meet residents' care needs. For example, residents with symptoms of infection did not have a care plan to guide appropriate care practices to support the management and control of their infection. In addition, some care plans had not been updated to reflect changes in residents

nutritional status. As a result, staff did not always have up-to-date guidance on how residents changing needs were to be supported.

A review of the care environment found that the premises, including bedrooms, en-suite facilities, and communal areas were generally clean and well-maintained. The provider had cleaning procedures and systems in place to support environmental hygiene. However, infection prevention and control practices did not consistently ensure that residents were fully protected from the risk of infection. In particular, arrangements for the management of equipment and the identification and monitoring of residents with symptoms of infection did not fully ensure effective infection prevention and control.

This inspection found there was mixed levels of compliance relating to fire safety. The provider had taken significant and proactive actions to enhance fire safety management within the centre. Substantial works had been undertaken, including the replacement of fire doors throughout the centre, particularly within residents' accommodation, to support effective containment and evacuation in the event of a fire emergency. The doors to bedrooms were widened to improve evacuation procedures. The provider also fitted swing-free devices to all bedroom doors, which were connected to the fire detection and alarm system. This meant that residents have a choice to have their door open but would close if the fire alarm was activated, preventing the spread of fire and smoke. Further work included a new gas detection system in the kitchen, which was a safety feature to shut off the gas if detected. Notwithstanding the programme of work to improve fire safety measures in the centre, inspectors identified areas of risk that are discussed in more detail under Regulation 28: Fire Precautions.

The provider was also progressing a planned programme of works to improve aspects of the premises. These works included reconfiguration of office spaces to better support nursing and administration duties, and changes to the layout of the centre to provide residents with additional private space, including the relocation of designated smoking areas. Residents bedroom accommodation generally met regulatory requirements in terms of space and storage provision. However, storage capacity within the centre was limited, which resulted in some equipment, including mobility and transfer aids, being stored in residents' bedrooms. Designated storage areas in the centre were not all being managed effectively; inspectors saw adhoc storage on the staff corridor and the large general store room was not organised.

The provider had taken action to ensure residents were provided with opportunities to participate in activities in accordance with their interests and capacities. There was a programme of activities available in the centre and residents appeared to enjoy music, chats, and individual activities with an activities co-ordinator. Residents told the inspector that they were satisfied with the activities on offer and enjoyed the social aspect of group activities.

Residents' rights were upheld in the centre, and staff placed a strong emphasis on supporting residents to exercise choice in their daily lives. Residents were supported to direct their own care, including decisions relating to their healthcare and the care

and supports they received from staff. This approach promoted residents autonomy and participation in decisions about their day-to-day lives.

Regulation 11: Visits

The registered provider had arrangements in place to facilitate residents to receive visitors in either their private accommodation or in a designated visiting area. Visits to residents were not restricted.

Judgment: Compliant

Regulation 17: Premises

Having regard to the needs of residents, the provider had not ensured that the premises fully complied with the requirements of Schedule 6 of the regulations, for example:

- There was inadequate storage for equipment such as hoists and mobility aids that were being stored within a three bedded room, which reduced the available space for residents. Some equipment, such as a trolley in the hairdresser room, was rusted. In addition, a room to the rear had mixed storage, was not organised and difficult to navigate through. There was a large volume of personal protective equipment (PPE) being stored on a staff corridor.
- The water temperature in the sink in the residents toilet in the reception area was not regulated and was excessively hot when tested.
- While pendant alarms were in use, the call bell system was not extended to the smoking areas, the garden area and the hairdressing room.
- A light fitting was taped to the water pipe over the hot water tank. This was not an appropriate arrangement for a light fitting.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was a failure to deliver food and nutrition to residents in line with regulatory requirements. This was evidenced by;

- Inspectors found that residents who had been assessed by health care professionals as requiring therapeutic diets tailored to their specific medical conditions, including high-protein and high-calorie diets to manage their

weight, were not receiving diets in line with these recommendations. A significant amount of residents had lost weight in the centre over the past three months.

- The food provided to residents was not always wholesome or nutritious. Some residents, who were prescribed a modified consistency diet were not provided with a choice of foods for their evening meal. This did not represent a balanced meal, nor was it in line with the food consistency recommended by a health care professionals.
- Some residents did not consume their tea-time meal, including one resident identified as requiring close monitoring due to weight-loss. This was not observed, monitored or escalated by staff.

Due to the level of risk identified under this regulation, an urgent compliance plan was requested from the provider. The response received provided assurance that the risks identified had been addressed.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not fully meet the requirements of Regulation 27, Infection control and the National Standards for infection prevention and control in community services (2018). For example;

- A number of resident had presented with respiratory infection within the same period of time. While the affected residents had received COVID antigen testing, there was no evidence that testing for other infections such as influenza, respiratory syncytial virus (RSV) was undertaken, in line with national guidance.
- While a system was in place to identify and manage residents who had a multi-drug resistant organism (MDRO), this system was not consistently implemented in practice. Staff were not always aware of residents who required additional infection prevention and control precautions, which posed a potential risk of cross infection. The implementation of this system was not subject to adequate monitoring to ensure it was being effectively applied in practice.

The environment was not always managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- Resident's equipment and products were not stored in a manner that reduced the risk of cross contamination. For example, in a communal bathroom in the reception area, a urinal was not returned to the sluice room and were observed on the floor beside a toilet. Residents continence wear was also stored in a cupboard under the sink.

- A raised toilet, used to support residents with mobility needs, was observed to be visibly unclean on inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the upgrade works which were ongoing to improve fire safety measures in the centre, the arrangements for fire safety were not in line with the requirements of the regulations

Immediate action was required of the provider to address a risk identified during the inspection. There was combustible items within a storeroom, positioned against electrical panels. The provider immediately arranged for this to be addressed and removed the inappropriate storage.

The provider was not taking adequate precautions against the risk of fire;

- An oxygen cylinder was inappropriately positioned near an electrical extension wire and sockets.
- Surplus chairs, were stacked and stored near two exits and a waste bin in front of another, causing potential obstructions during evacuation.
- A new nurse station was provided within the reception, which was not enclosed in fire rated construction. There was no risk assessment to determine appropriate controls to manage fire risks within this area, which shared a corridor with two bedrooms.
- There was an attic used for storage, posing a risk of the spread of fire within the attic.
- The smoking area was not equipped with the appropriate fire extinguisher, nor was there a call bell to summon assistance, if required.
- The risk of fire from non-registered areas of the building and buildings adjacent to the centre had not been risk assessed in relation to a potential risk posed to the residents within the registered centre.

The registered provider did not provide adequate means of escape, including emergency lighting, for example:

- The provision of emergency lighting along external escape routes was not adequate to safely guide occupants from the exits to a place of safety if the power in the building failed.
- The provision of exit signage was not adequate in all areas. For example, within some areas of the front corridor, there was a lack of visible escape signage to direct occupants towards the next compartment or exits.

Notwithstanding the improvements being made to fire containment and the upgrade of the fire detection and alarm system, arrangements in place were not aligned to the requirements of the regulations. For example:

- The fire doors into the laundry, a room of increased risk achieved thirty minutes only and not sixty minutes.
- Ceilings and attic hatches were not appropriately fire rated.
- There was an excessive gap at the bottom of two bedroom fire doors and the dining room door, which may impact of the containment of smoke and fire.

In terms of fire safety management and fire drills, the provider was conducting regular simulated drills. These did not contain sufficient information to demonstrate that the evacuation procedures were effective. For example, during the programme of work, fire doors to bedrooms did not have automatic closers fitted. The drills did not reflect that staff had additional responsibility to manually close the doors in the event of a fire. Staff spoken with gave mixed responses to the inspectors regarding the closing of fire doors and indicated there was no additional training delivered for this.

The inspector reviewed the ski sheets on a sample number of beds and found some were not correctly fitted, which may lead to a delay during evacuation. This was addressed during the inspection.

The provider confirmed to the inspectors that fire compartments had been assessed by an engineer for effectiveness and this was evidenced from a fire safety assessment in December 2023, however the size and extent of the fire compartment boundaries could not be confirmed. If management and staff are not aware of the correct fire compartment boundaries, this may result in residents being evacuated into areas that are not safe.

The provider had assessed the evacuation needs of residents with a personal emergency evacuation plan (PEEP). These were consolidated into summary document which contained pertinent information such as the evacuation aid required and the number of staff required to assist, however some of the content was not accurate; the provider committed to updating this during the inspection.

Fire equipment and building services were not appropriately maintained. For example, while there was an annual certificate for the emergency lighting dated June 2025, there was no evidence that the interim quarterly service reports were being completed.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations. For example;

- Care plans were not always guided by a comprehensive or accurate assessment of the resident's care needs. For example, some residents' care plans did not accurately reflect the needs of the residents and did not identify appropriate interventions to support residents when identified as being at a high risk of malnutrition.
- Several care plans, for residents with infection, had not been updated to provide adequate information to guide infection prevention and control measures during care delivery. Consequently, not all staff had awareness of residents infection status and individual needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP) and GPs were visiting the centre, as required.

Residents were provided with access to a range of health and social care professionals. This included physiotherapy, dietitian services, speech and language therapy, tissue viability nursing expertise, psychiatry of old age, and palliative care.

While referral pathways to health and social care professionals, including dietetics, were in place, it was not demonstrated that dietetic recommendations and care plans were implemented in practice. This is actioned under Regulation 18: Food and nutrition.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that residents' rights were upheld in the centre and their privacy and dignity was respected. Residents were consulted for their feedback on the quality and safety of the service.

Residents were provided with meaningful activities seven days per week. Records captured each residents involvement and level of participation in scheduled activities.

Residents were supported to exercise their religious beliefs and were facilitated to attend religious services in both the centre and in their community.

Information pertaining to independent advocacy services was prominently displayed in the centre. Residents could access the services independently through a system of referral or independently through telephone.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for West Clare Nursing Home St Theresa's Kilrush OSV-0000451

Inspection ID: MON-0049615

Date of inspection: 03/03/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The Person in Charge (PIC) will strengthen supervision and governance arrangements to ensure that clinical documentation, care planning, and the implementation of care are accurate, consistent, and aligned with residents' assessed needs and professional recommendations. Actions to be implemented: • Immediate review of all resident assessments, care plans, nursing documentation, referrals, medical reviews, and allied health professional recommendations by the PIC and Clinical Nurse Manager (CNM). • Immediate correction and updating of any identified gaps or inconsistencies to ensure records accurately reflect current resident needs and care interventions. • Introduction of a structured clinical audit programme including: - o Monthly audits of care plans and assessments - o Monthly audits of nursing documentation and referral pathways - o Monthly audits of implementation of allied health professional recommendations • Audit findings to be: - o Recorded and trended - o Discussed at clinical governance meetings - o Used to inform targeted quality improvement actions • Implementation of a structured staff supervision programme for all nursing staff including: - o Regular one-to-one supervision sessions - o Review of documentation practice during supervision - o Observational assessment of care delivery in practice - o Feedback on adherence to care plans and clinical standards • Refresher training programme for all nursing staff covering: - o Assessment and care planning - o Accurate and contemporaneous documentation - o Record keeping and referral documentation	

- o Implementation of allied health and medical recommendations
 - o Professional accountability and clinical governance responsibilities
 - Strengthening of communication systems to support safe care delivery, including:
 - o Clear handover processes highlighting residents requiring specific interventions
 - o Communication of updated care plans and changes in clinical recommendations to all relevant staff
 - Ongoing governance and oversight by the PIC:
 - o Monthly review of audit results, supervision outcomes, and compliance indicators
 - o Identification of trends and risks
 - o Integration of findings into the centre's quality improvement plan
 - o Monitoring of actions until sustained compliance is demonstrated
- Person Responsible: Person in Charge and Clinical Nurse Manager
- Timeframe:
- Immediate review and corrective actions: within 21 days
 - Training, supervision, and audit system fully implemented: within 6 weeks
 - Ongoing monitoring: continuous thereafter as part of governance framework

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Regulation 21: Records

Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
The Person in Charge (PIC) will ensure that all records required under Regulation 21 and Schedules 3 and 4 are complete, accurate, up to date, and readily accessible at all times to support safe and effective resident care and regulatory compliance.

Actions to be implemented:

- Immediate full review of all resident clinical records to ensure the following are accurately documented and available on file:
 - o Medical assessments, GP reviews, and treatment plans
 - o Specialist reviews and interventions
 - o Nutritional assessments, monitoring charts, and dietetic input
 - o Nursing care records and ongoing care interventions
- Immediate follow-up with relevant healthcare professionals (GPs, dietitians, specialists) to obtain any missing documentation and ensure it is filed in resident records without delay.
- Introduction of a daily and weekly record management system to ensure:
 - o All clinical entries are filed contemporaneously
 - o External correspondence (GP letters, hospital reports, specialist reviews) is filed on receipt
 - o Nursing documentation is completed and signed at point of care or end of shift
- Implementation of a "Readily Accessible Records System" ensuring:
 - o All resident records are clearly indexed and stored in a consistent format
 - o Staff can locate any required record immediately during inspection or clinical review

- o A designated staff member on each shift is responsible for records availability and filing
- Fire safety and maintenance records:
 - o Immediate audit of all fire safety documentation including fire alarm checks, emergency lighting testing, servicing records, and evacuation drills
 - o Ensure all statutory maintenance and testing records are up to date and filed in a central compliance folder
 - o Establish a scheduled system for recording and signing off all fire safety checks
- Staff training and awareness:
 - o Refresher training for all relevant staff on record keeping requirements under Regulations 21 and Schedules 3 & 4
 - o Emphasis on timely documentation, accuracy, and accountability
 - o Guidance on filing, retrieval, and maintaining inspection-ready records
- Governance and oversight:
 - o Weekly record audits by the Clinical Nurse Manager (CNM) for the first 8 weeks, reducing to monthly once compliance is established
 - o Monthly PIC review of record audit outcomes and compliance
 - o Escalation and immediate corrective action for any gaps identified
 - o Inclusion of record management in the centre's quality improvement plan and governance agenda

Person Responsible: Person in Charge and Clinical Nurse Manager

Timeframe:

- Immediate review and correction of records: within 14 days
- Full implementation of improved record management system: within 6 weeks
- Fire safety records audit and correction: within 7 days
- Ongoing audits and governance monitoring: continuous thereafter

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

The Person in Charge (PIC) and Provider Nominee will strengthen governance, accountability, and oversight systems within the centre to ensure clear lines of authority, effective monitoring of clinical and environmental risks, and timely escalation and response to identified issues. This will ensure that all aspects of care and service delivery are consistently monitored, risks are identified early, and appropriate actions are taken to maintain compliance and resident safety.

Actions to be implemented:

- Clearly define and document the management structure, including:
 - o Specific allocation of responsibilities across the Nurse Management Team
 - o Named leads for infection control, fire safety, records management, clinical care, and nutritional care
 - o Clear reporting lines and escalation pathways to the PIC and Provider Nominee

- o Communication of roles and responsibilities to all staff
- Strengthen governance oversight systems by implementing a formal governance framework that includes:
 - o Weekly clinical and operational governance meetings chaired by the PIC
 - o Standing agenda items covering nutrition, infection control, fire safety, records, staffing, and clinical risks
 - o Documented review of all audit outcomes, incidents, and risk indicators
 - o Clear escalation of risks to senior management with documented follow-up actions
- Nutrition and weight management improvements:
 - o Immediate full review of all residents' nutritional status and weight records
 - o Identification of residents with weight loss or nutritional risk and immediate referral to GP/dietitian where required
 - o Implementation of individualised nutritional care plans with clear monitoring frequency and review dates
 - o Weekly monitoring of residents at nutritional risk until stabilised, then reviewed monthly
 - o Designation of a named nurse responsible for oversight of nutritional care in each unit
- Strengthening of audit and monitoring systems:
 - o Review and revision of all existing audit tools to ensure they are effective in identifying practice issues
 - o Introduction of outcome-focused audits (not just checklist compliance)
 - o Monthly audit schedule covering:
 - Infection control
 - Fire safety
 - Nursing documentation and care records
 - Staff supervision
 - Nutritional care and weight monitoring
 - o Audit findings to be trended, analysed, and escalated where risks are identified
- Fire safety and environmental governance:
 - o Appointment of a designated Fire Safety Lead
 - o Weekly environmental and fire safety checks with documented sign-off
 - o Monthly review of fire drills, equipment checks, and evacuation readiness
 - o Immediate escalation of any deficits to the PIC
- Infection prevention and control (IPC) governance:
 - o Appointment of a named IPC lead nurse
 - o Weekly IPC audits including hand hygiene, PPE compliance, and outbreak preparedness
 - o Regular IPC education and reinforcement sessions for staff
 - o Clear escalation pathway for any IPC risks or outbreaks
- Staff supervision and accountability:
 - o Structured supervision programme for all nursing and care staff
 - o Regular competency assessments linked to clinical practice areas (nutrition, documentation, IPC, fire safety awareness)
 - o Supervision outcomes recorded and reviewed at governance meetings
- Monitoring and assurance:
 - o Monthly governance report compiled by PIC for Provider Nominee review
 - o Key performance indicators (KPIs) introduced for:
 - Nutrition and weight stability
 - Audit completion and outcomes
 - Incident and risk escalation

- Supervision completion rates
- o External or independent audit review to be considered periodically to validate internal systems

Person Responsible: Provider Nominee and Person in Charge

Timeframe:

- Governance structure and role allocation: within 14 days
- Nutritional care review and interventions: immediate (within 7 days)
- Revised audit and governance system fully operational: within 6 weeks
- Ongoing monitoring, auditing, and reporting: continuous thereafter

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Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The Provider and Person in Charge will ensure that the premises are maintained, organised, and adapted in line with Schedule 6 requirements and in a manner that supports resident safety, dignity, accessibility, and effective service delivery. A structured environmental improvement programme will be implemented to address identified deficits and strengthen ongoing monitoring and maintenance systems.

Actions to be implemented:

- Immediate environmental safety review of all areas of the centre to include:
 - o Storage of equipment, mobility aids, and PPE
 - o Condition of furniture and equipment
 - o Accessibility and safe use of all rooms and communal spaces
 - o Identification and removal of any unsafe or inappropriate installations
- Storage and equipment management:
 - o Immediate relocation of hoists, mobility aids, and equipment from resident bedrooms to designated storage areas
 - o Reorganisation of storage rooms to ensure they are clearly labelled, accessible, and free from clutter
 - o Removal of rusted or unsafe equipment and replacement where required
 - o Reduction and proper storage of PPE stock in designated clean storage areas only
 - o Implementation of a monthly storage audit to maintain compliance and prevent recurrence
- Water safety:
 - o Immediate assessment and adjustment of water temperature controls in all resident-accessible sinks and toilets
 - o Installation or verification of thermostatic mixing valves (TMVs) where required
 - o Introduction of a scheduled water temperature monitoring system with documented checks
- Call bell / resident alert systems:
 - o Review of full call bell coverage across the premises

- o Extension of call bell system to all resident-accessible areas including:
 - Smoking areas
 - Garden areas
 - Hairdressing room
- o Interim risk mitigation measures implemented where systems are not yet fully installed
- o Testing of all call points as part of monthly maintenance checks
 - Electrical and environmental safety:
- o Immediate removal and correction of unsafe fittings (e.g. taped light fixtures or inappropriate installations)
- o Full electrical safety review of affected areas
- o Engagement with qualified maintenance personnel to ensure compliance with safety standards
- o Documentation of all remedial works completed
 - Governance and maintenance systems:
- o Introduction of a structured environmental checklist completed weekly by maintenance and nursing staff
- o Monthly environmental audit conducted by the Clinical Nurse Manager and maintenance lead
- o Findings escalated to the Person in Charge and included in governance review meetings
- o Actions tracked to completion with clear responsibility and deadlines
 - Staff awareness and accountability:
- o Staff education on maintaining safe, clutter-free environments
- o Clear responsibility assigned for reporting environmental hazards immediately
- o Reinforcement of infection prevention and safety standards relating to storage and cleanliness

Person Responsible: Person in Charge and Maintenance Supervisor

Timeframe:

- Immediate removal of hazards and unsafe equipment: within 48 hours
- Storage reorganisation and PPE relocation: within 2 weeks
- Call bell system extension planning and commencement: within 6 weeks
- Water temperature safety controls review and adjustment: within 7 days
- Full environmental audit system implementation: within 6 weeks
- Ongoing monitoring: continuous thereafter

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Regulation 18: Food and nutrition	Not Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: The Person in Charge (PIC) will strengthen the systems for assessing, monitoring, delivering, and reviewing residents' nutritional care to ensure that all residents receive adequate, nutritious, and appropriate food and fluids in accordance with their assessed	

needs, preferences, and specialist recommendations. Actions to be implemented: An immediate review of all residents identified as being at nutritional risk, experiencing weight loss, or requiring a therapeutic or modified consistency diet.

Compliance Plan – Regulation 18: Food and Nutrition

The Person in Charge (PIC) will strengthen the systems for assessing, monitoring, delivering, and reviewing residents' nutritional care to ensure that all residents receive adequate, nutritious, and appropriate food and fluids in accordance with their assessed needs, preferences, and specialist recommendations.

Actions to be implemented:

- An immediate review of all residents identified as being at nutritional risk, experiencing weight loss, or requiring a therapeutic or modified consistency diet.
- All nutritional care plans will be reviewed and updated to ensure they accurately reflect current dietetic, speech and language therapy (SLT), GP, and other specialist recommendations.
- A multidisciplinary review will be completed for all residents who have experienced significant or unplanned weight loss, with referrals made to the GP, Dietitian, and Speech and Language Therapist, as appropriate.
- A named nurse will be assigned responsibility each week for oversight of residents at nutritional risk, including:
 - o Monitoring food and fluid intake records
 - o Monitoring weight trends
 - o Ensuring prescribed nutritional interventions are implemented
 - o Escalating concerns promptly to the clinical management team
- Residents prescribed therapeutic diets, fortified diets, high-calorie diets, high-protein diets, or modified consistency diets will receive meals and snacks in accordance with specialist recommendations at all times.
- Choice at mealtimes will be strengthened by ensuring:
 - o Residents on modified consistency diets are offered the same variety and choice as other residents wherever possible
 - o Menus reflect residents' preferences and dietary needs
 - o Alternative meal options are available if a resident declines the meal offered
- A mealtime monitoring system will be implemented to ensure:
 - o Residents requiring assistance receive timely support
 - o Poor dietary intake is identified promptly
 - o Uneaten meals are recorded
 - o Concerns are escalated to nursing staff without delay
- Residents identified as nutritionally vulnerable will have:
 - o Weekly weights or more frequently if clinically indicated
 - o Food and fluid intake monitoring as required
 - o Monthly nutritional review or sooner if concerns arise
 - o Outcomes discussed at clinical risk and governance meetings
- Training will be provided to nursing, healthcare, and catering staff on:
 - o Nutritional risk identification
 - o MUST assessments
 - o Therapeutic and modified consistency diets
 - o Mealtime assistance and monitoring
 - o Escalation procedures for poor intake and weight loss
- Governance and oversight arrangements will be strengthened through:

- o Weekly audits of food and fluid charts for residents at risk
- o Monthly audits of nutritional care plans, weights, and specialist recommendations
- o Monthly review of all residents with weight loss by the PIC and Clinical Nurse Manager
- o Review of nutritional outcomes at governance meetings, with actions tracked to completion

Person Responsible: Person in Charge, Clinical Nurse Manager, Catering Manager, and Registered Nursing Staff

Timeframe:

- Immediate review of residents at nutritional risk and implementation of interventions: within 48 hours
- Review and update of all nutritional care plans: within 14 days
- Staff training and strengthened monitoring systems: within 6 weeks
- Audit and governance systems: implemented immediately and ongoing thereafter

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Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: The Person in Charge (PIC) will strengthen infection prevention and control (IPC) systems, staff awareness, environmental hygiene practices, and governance arrangements to ensure compliance with Regulation 27 and the National Standards for Infection Prevention and Control in Community Services (2018). Actions to be implemented: Infection Surveillance and Management • All residents presenting with symptoms of respiratory infection will be assessed in line with current national guidance. • The centre's outbreak management and respiratory infection pathways will be reviewed to ensure residents are tested and managed appropriately for COVID-19, Influenza, RSV, and other relevant respiratory infections where clinically indicated. • A respiratory infection checklist will be introduced to support staff in the timely recognition, testing, monitoring, and escalation of residents presenting with symptoms of infection. • The Clinical Nurse Manager (CNM) will review all suspected or confirmed infections weekly to ensure appropriate actions have been implemented and documented. Management of Residents with MDROs • A full review of all residents identified as having a Multi-Drug Resistant Organism (MDRO) will be undertaken. • Care plans, risk assessments, and infection prevention precautions will be reviewed and updated to ensure they accurately reflect current needs. • A clear system will be implemented to ensure staff are aware of residents requiring transmission-based precautions while maintaining resident confidentiality and dignity. • Daily oversight by the nurse in charge will ensure infection prevention precautions are consistently implemented. • Monthly audits will be completed to assess compliance with MDRO management	

procedures and identify opportunities for improvement.

Environmental Hygiene and Equipment Management

- Immediate review of storage practices throughout the centre to ensure resident equipment and care items are stored appropriately and in a manner that reduces the risk of cross contamination.
- All communal bathrooms, sluice facilities, and clinical areas will be reviewed to ensure equipment is cleaned, stored, and returned to designated areas following use.
- Appropriate storage arrangements will be implemented for continence products and resident equipment.
- A deep clean of identified areas and equipment will be completed, including all mobility and toileting aids.
- Enhanced environmental hygiene inspections will be completed weekly by the housekeeping lead and reviewed by the CNM.

Staff Training and Awareness

- Refresher training will be provided to all staff on:
 - o Standard and transmission-based precautions
 - o MDRO management
 - o Respiratory infection management
 - o Environmental hygiene and equipment decontamination
 - o Safe storage of resident equipment and care products
- Staff understanding and compliance will be monitored through supervision, observation of practice, and audit findings.

Governance and Quality Assurance

- The IPC Lead will undertake monthly IPC audits covering:
 - o Environmental cleanliness
 - o Equipment storage and decontamination
 - o MDRO management
 - o Staff compliance with infection prevention measures
 - o Respiratory infection surveillance and management
- Audit findings will be reviewed at monthly governance meetings.
- Any deficits identified will be addressed through corrective action plans with clear responsibilities and timelines.
- IPC will remain a standing agenda item at management and clinical governance meetings to ensure ongoing oversight and monitoring.

Person Responsible: Person in Charge, Clinical Nurse Manager, IPC Lead Nurse, and Housekeeping Supervisor

Timeframe:

- Immediate correction of storage and environmental hygiene issues: within 48 hours
- Review of MDRO management systems and resident care plans: within 14 days
- Staff training and implementation of revised monitoring systems: within 6 weeks
- Audit and governance arrangements: implemented immediately and ongoing thereafter

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Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Provider and Person in Charge (PIC) will implement a comprehensive fire safety improvement programme to ensure full compliance with Regulation 28. This will strengthen fire prevention, containment, detection, evacuation arrangements, staff competency, and governance oversight to ensure the safety of all residents, staff, and visitors. Actions to be implemented: Fire Safety Risk Management and Environmental Controls • Immediate removal and ongoing prevention of combustible storage near electrical panels and other high-risk areas. • Safe relocation and designated storage for oxygen cylinders in accordance with fire safety guidance. • Immediate clearance of all escape routes, including removal of surplus chairs, waste bins, and any obstructions near exits. • Formal fire risk assessment to be completed for: - o Reception Nurses Office - o Attic storage areas - o Non-registered areas and adjacent buildings - o Smoking areas and all high-risk communal spaces • All identified risks to be addressed through a documented action plan with clear responsibilities and timelines. Means of Escape, Signage and Emergency Lighting • Full review and upgrade of emergency lighting systems, particularly along external escape routes, to ensure safe evacuation during power failure. • Installation and/or replacement of exit signage to ensure all escape routes are clearly visible and direct occupants safely to exits and assembly points. • Monthly testing of emergency lighting and signage visibility checks to be implemented and recorded. Fire Containment and Structural Fire Safety • Upgrade of fire doors, ceilings, attic hatches, and compartmentation to ensure compliance with required fire resistance standards. • Replacement of fire doors where required to achieve 60-minute fire resistance in high-risk areas such as the laundry. • Correction of excessive gaps under fire doors and installation of appropriate seals and closing mechanisms. • Completion of a full fire compartmentation survey to clearly identify and confirm all fire compartment boundaries. • Fire compartment maps to be made available to all staff and incorporated into evacuation training and procedures. Fire Safety Equipment and Maintenance • Installation of appropriate fire extinguisher and emergency call system in smoking areas. • Review and upgrade of all fire safety equipment placement and accessibility. • Implementation of a documented maintenance schedule ensuring: - o Quarterly emergency lighting checks are completed and recorded - o All fire equipment servicing is up to date - o All certificates and inspection reports are retained and accessible for inspection	

Evacuation Procedures and Staff Training

- Full review and update of all Personal Emergency Evacuation Plans (PEEPs) to ensure accuracy and reflect current resident needs.
- Correction of inaccuracies in evacuation equipment requirements and staffing levels.
- Staff training to include:
 - o Fire door management (including manual closing where automatic closers are not present)
 - o Evacuation procedures aligned to current building layout and fire compartmentation
 - o Use and fitting of evacuation aids, including ski sheets
 - o Awareness of fire compartment boundaries and safe evacuation zones
- Refresher fire drills to be conducted to reflect:
 - o Night-time scenarios
 - o Limited staffing conditions
 - o Manual fire door closure procedures should swing free system malfunction
 - o Full evacuation simulations aligned to current risks

Governance, Oversight and Assurance

- Weekly fire safety environmental checks conducted by Maintenance and Nursing Management.
- Monthly fire safety audits completed by the PIC with ADON/CNM, with findings reviewed at governance meetings.
- All actions from audits and risk assessments tracked through a formal fire safety improvement plan.
- Clear escalation processes to ensure any fire safety risks are immediately reported and addressed.
- Fire safety to remain a standing agenda item at clinical and operational governance meetings.

Person Responsible: Provider Nominee, Person in Charge, Fire Safety Consultant, Maintenance Manager, and Clinical Nurse Manager

Timeframe:

- Immediate removal of identified hazards and obstruction risks: within 48 hours
- Fire risk assessments and PEEP review: within 14 days
- Emergency lighting and signage improvements: within 6 weeks
- Fire containment and structural works: completed in line with agreed contractor schedule
- Training and revised fire drills: within 6 weeks
- Governance and audit systems: implemented immediately and ongoing thereafter

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Regulation 5: Individual assessment and care plan

Substantially Compliant

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

The Person in Charge (PIC) will strengthen the assessment, care planning, and review processes within the centre to ensure that all residents have comprehensive assessments

and person-centred care plans that accurately reflect their current needs, risks, preferences, and required interventions.

Actions to be implemented:

Assessment and Care Planning

- A full review of all resident assessments and care plans will be completed to ensure they accurately reflect residents' current needs and identified risks.
- Residents identified as being at risk of malnutrition will have their assessments, risk screenings, and nutritional care plans reviewed and updated to ensure appropriate interventions are clearly documented.
- Care plans will clearly identify:
 - o The resident's assessed needs
 - o Specific risks identified
 - o Required interventions
 - o Monitoring arrangements
 - o Review dates and outcomes
- Any changes in a resident's condition, risk status, treatment, or specialist recommendations will result in an immediate review and update of the care plan.

Infection Prevention and Control Care Planning

- All residents with a confirmed or suspected infection, including residents with Multi-Drug Resistant Organisms (MDROs), will have an individualised care plan in place.
- Infection-related care plans will clearly outline:
 - o The resident's infection status
 - o Required infection prevention and control precautions
 - o Care interventions required
 - o Monitoring and review arrangements
- Nursing staff will ensure that infection-related care plans are reviewed and updated promptly following any change in condition, diagnosis, or specialist advice.

Staff Training and Supervision

- Refresher training will be provided to all nursing staff on:
 - o Comprehensive assessment processes
 - o Person-centred care planning
 - o Nutritional risk assessment and management
 - o Infection prevention and control care planning
 - o Documentation and record-keeping standards
- The Clinical Nurse Manager (CNM) will provide ongoing supervision and support to nursing staff to ensure care plans remain accurate, current, and reflective of residents' needs.

Audit and Governance

- Monthly audits of resident assessments and care plans will be completed by the CNM.
- Audits will specifically review:
 - o Accuracy of assessments
 - o Alignment between identified risks and care plan interventions
 - o Nutritional care planning
 - o Infection prevention and control care plans
 - o Timeliness of reviews and updates
- Audit findings will be discussed at clinical governance meetings and any identified deficits will be addressed through corrective action plans.
- Trends and recurring issues will be monitored to support continuous quality improvement.

Person Responsible: Person in Charge and Clinical Nurse Manager

Timeframe:

- Review and update of all identified care plans: within 14 days
- Staff training and supervision programme: within 6 weeks
- Monthly audit and governance processes: implemented immediately and ongoing thereafter

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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 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	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 the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/07/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	16/06/2026
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Substantially Compliant	Yellow	16/06/2026

Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Red	09/03/2026
Regulation 21(1)	The registered provider shall 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.	Substantially Compliant	Yellow	31/07/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details	Substantially Compliant	Yellow	31/07/2026

	responsibilities for all areas of care provision.			
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.	Substantially Compliant	Yellow	31/07/2026
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.	Substantially Compliant	Yellow	31/07/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	16/06/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/07/2026

Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	16/06/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/07/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	31/07/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals,	Substantially Compliant	Yellow	31/07/2026

	that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	16/06/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	16/06/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident	Substantially Compliant	Yellow	16/06/2026

	concerned and where appropriate that resident's family.			
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