



**Health
Information
and Quality
Authority**

An tÚdarás Um Fhaisnéis
agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Tralee Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Teile Carraig, Killerisk Road, Tralee, Kerry
Type of inspection:	Unannounced
Date of inspection:	13 July 2026
Centre ID:	OSV-0000566
Fieldwork ID:	MON-0048875

About the designated centre

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

Tralee Community Nursing Unit is a designated centre located in the urban setting of the town of Tralee. It is registered to accommodate a maximum of 46 residents. It is a single-storey facility set on a large site. Residents' bedroom accommodation is set out in two units, Loher unit with 24 beds and Dinish unit with 22 beds. Each unit is self-contained with a dining room, kitchenette, day room. Bedroom accommodation comprises of single, twin, one three bedded room and four bedded rooms. The Rose Café is located at the entrance to the centre has café style seating. The atrium is a large communal space located between the two units with comfortable seating. The quiet visitors room is located between both units. The oratory is situated on the corridor by the main entrance. Tralee Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	43
--	----

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 13 July 2026	13:30hrs to 19:30hrs	Erica Mulvihill	Lead
Tuesday 14 July 2026	09:00hrs to 14:45hrs	Erica Mulvihill	Lead

What residents told us and what inspectors observed

This unannounced inspection took place over two days by an inspector of social services. Overall, there was a pleasant atmosphere and residents appeared relaxed and comfortable in their surroundings. The inspector met with many of the 43 residents over the two days and spoke with 19 in detail to gain an insight into their experience of living in Tralee Community Nursing Unit. Residents gave positive feedback about the centre and highly regarded the staff and management of the centre. Three residents did, however, highlight that there are staff who come to work in the centre (agency staff) and are not known to the residents and they expressed their preference for staff who would know their care requirements well and who are working in the centre full time as it made them more comfortable.

On arrival, the inspector met with the person in charge of the centre after following the sign in process. The inspector walked through the centre and spent time talking to residents and staff and some visitors who were in the centre visiting their loved ones and observing the care environment. Staff who were on duty were observed to be busy but respectful and were observed knocking before entering resident bedrooms and attending to residents in a timely manner. After the walk through, the inspector met with the person in charge and held a short introductory meeting.

Tralee Community Nursing Unit provides long term care for both male and female residents with a range of dependencies and requirements. The centre is situated in the town of Tralee in County Kerry and is registered to provide care to 46 residents. On the day of the inspection there were 43 residents living in the centre. The centre comprises two wings, Loher which has 24 beds, and Dinish which has 22 beds, each unit has their own day room and dining room for resident use. Since the last inspection, further upgrades to flooring in bedrooms had been completed. Bedrooms in general in the centre were clean and tidy and were appropriately decorated.

Residents had access to storage for their personal possessions; each had access to a double wardrobe and a lockable locker. Bedroom accommodation in the centre comprised of five four bedded rooms, one three bedded room, two twin rooms and 19 single rooms. The majority of residents have access to a shared bathroom with three rooms having en suite facilities.

A large communal area was available to residents between the two units, Loher and Dinish and a number of residents were observed making jigsaws, eating ice cream in the adjacent garden space and some taking part in an exercise class. The hairdresser was onsite during the first day of inspection and many of the female residents were seen enjoying getting their hair done.

On the second morning, some residents were going into the local town to go shopping with the activity coordinator whilst the other residents who chose to stay in the centre enjoyed exercises, reading the paper and artwork. Residents were very

thankful for the high level of social engagement they were offered and some residents were looking forward to a bird watching day out the centre had planned which was taking place in the coming days. In Dinish ward, in the afternoon, three male residents were observed watching a world cup soccer match which the staff had played for them.

Visitors were seen to freely access the centre during the two days of the inspection and the inspector spoke in detail to ten visitors. Overall, they were all happy with the centre and remarked on the homely environment and that their relatives were happy living there, however, four visitors commented on the increased numbers of agency staff working in the centre and that they had raised concern to management as they felt the residents assessed care needs were not always met due to agency staff not knowing residents well. One of the visitors told the inspector that they had requested a meeting with the provider to discuss their concerns and were awaiting a date for this meeting to be arranged.

The inspector spent time observing mealtimes and speaking to residents in relation to the quality of food and the dining experience in the centre over the course of the two days. Residents stated that the quality of food had much improved and that they were offered fresh baked goods daily with one resident stating they really looked forward to a fresh scone with their evening meal as they used to have this at home. The onsite kitchen provided residents with a choice of meal options at mealtimes and an alternative could be requested if required.

Notwithstanding the positive improvements, the dining experience for residents in the centre required further action. In both units, tables were not set for the lunchtime meal or the evening meal. On the first day of the inspection, at the evening meal, staff on both units were observed to sit next to residents who required assistance, however, they did not set cutlery or provide refreshments to residents whilst they were awaiting their meals. Observing the dining experience throughout the inspection, the inspector was not assured that mealtimes were conducive to a social dining experience for residents. This will be further discussed under the relevant regulations.

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, carried out by an inspector of social services over two days, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, as amended. The inspector also followed up on action taken by the provider since the previous

inspection in October 2025. The inspection found that whilst improvements were noted in some areas such as complaints management, some aspects of the management systems were not robust and did not provide adequate assurances that a safe, consistent and quality service was provided to residents living in the centre. These findings particularly related to the supervision of staff, restrictive practices systems and management oversight in relation to staffing.

The registered provider is the Health Service Executive (HSE). There was a clearly defined management structure in place. The person in charge worked full time in the centre. They were supported by a clinical nurse manager and a team of nursing, health care, household, catering and activity staff. Maintenance support to the centre was provided by South West Estates Tralee. The person in charge reports to a General Manager in the HSE, who was available for consultation and support as required. The centre is also supported by centralised departments, such as human resources, fire and estates and practice development.

A review of staffing in the centre showed that whilst there was sufficient staff on duty during the inspection to meet the needs of residents, based on a review of rosters, there was a concern in relation to the skill mix of staff. Similar to findings from the previous inspection, there was an increased usage of agency staff to fill deficits in rosters for nursing staff, care staff and also catering assistant staff. This did not promote continuity of care for residents from staff who knew them well, and may affect the consistency of care delivered. The centre had two residents with increased care needs who required one to one supervision and these rosters were consistently filled by agency staff therefore those residents were not cared for by staff who knew them well.

Records were reviewed including complaints raised by residents and families which detailed concern in relation to agency staff not being aware of individual care needs and two incidents where care delivery was impacted due to a lack of consistency of care. The centre had three new beds registered in July 2026 and management confirmed these beds cannot be opened as the centre does not have adequate staffing at present. Management locally gave assurances staffing for the centre is for review with the registered provider. This is actioned under Regulation 15: Staffing.

All staff had access to relevant training. Some training courses were mandatory for all staff, for example safeguarding of vulnerable persons and moving and handling. Well maintained training records were reviewed and evidence of further training schedules for future training sessions were available for review. However, the registered provider had inadequate arrangements in place to ensure appropriate levels of staff supervision were in place. This lack of staff supervision, monitoring and support had a direct impact on the delivery of health and social care to residents, as detailed under Regulation 16: training and staff supervision.

A review of the incident management system in the centre showed there was an increase in falls in the centre. The increase in falls were not reflected in the audit systems or trended to develop systems to reduce the incidence and provide

education for residents and staff. This is discussed under Regulation 23: Governance and management.

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider had named a Person participating in Management for the centre and had submitted the required documentation to the office of the Chief Inspector to meet regulatory requirements.

Judgment: Compliant

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The provider had submitted an application to vary Condition 1 and Condition 3 of the centres' registration. All documentation was received and the application was progressed to register three new beds in the centre.

Judgment: Compliant

Regulation 15: Staffing

Whilst the number of staff on duty during the days of the inspection were sufficient, a review of rosters did not assure the inspector that the skill mix in place in the centre was sufficiently robust. Rosters showed a deficit in nursing staff per week (2.5 whole time equivalents) and a deficit in care staff per week (1.5 whole time equivalents). This deficit was covered by agency staff to ensure a full roster could be maintained. The use of high levels of agency staff did not assure that continuity and consistency of care was always maintained.

For example:

- Two visitors to the centre had raised concern in relation to alterations in the consistency of care including access to personal belongings, adequate hydration and not following the residents care plan requirements.
- One resident raised a complaint in relation to incorrect medication administration by an agency staff looking after them.
- one relative also made a complaint in relation to incorrect medication administration given by an agency staff looking after their resident.
- The new three bedded room registered in July 2026 could not be opened due to a lack of staffing.

Judgment: Not compliant

Regulation 16: Training and staff development

There was poor supervision of staff who provided meals to residents. For example:

- Residents were seen not to be assisted into an optimal position to enable them to eat their meal. the inspector observed one resident had their tray placed on their bed table but they were in a supine position and were not sat up to facilitate the appropriate consumption of their meal.
- A number of residents were presented their meal on a hot tray from the kitchen trolley which was clinical in appearance and not conducive to a social model of care.
- two residents were sitting in the dining room asleep one hour after their main meal without staff supervision or being offered to go to one of the centres communal spaces post their meal.
- there was poor oversight of staff in relation to the use of restrictive practice measures as discussed under Regulation 7: Managing behaviours which are challenging.

Judgment: Not compliant

Regulation 19: Directory of residents

The directory of residents was maintained, up-to-date and contained all required details on admissions, discharges and deaths of residents.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured that records set out in Schedule 2, 3 and 4 of the regulations were available for inspection. A sample of three staff files were reviewed and had all the necessary documentation as required by regulation. All registered nurses in the centre had a copy of their up to date certificate from the Nursing and Midwifery Board of Ireland (NMBI) available to review.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured that there was a current and valid contract of insurance against injury to residents, and other risks including loss or damage to resident property.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding some improvements, the management systems in place required action to ensure that the service provided is safe, appropriate, consistent and effectively monitored. For example:

- the system in place for the supervision of staff was not sufficiently robust in relation to mealtimes in the centre and restrictive practice as discussed throughout this report.
- there was a lack of oversight in relation to policies and procedures as some were out of date.
- systems in relation to falls management required action. The number of falls in the centre were high based on a review of incidents, but were not trended and therefore evidence of quality improvement plans to mitigate the risk of falls were not available.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of the incident management system in the centre found that the person in charge of the designated centre informed the Chief Inspector of all notifiable incidents required by regulation within the required timeframes.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was displayed prominently in the reception of the centre. The registered provider had an accessible and effective procedure for dealing with complaints, which included a review process. The required timelines for the

investigation into, and review of complaints was specified in the procedure. A record of complaints was maintained in the centre, in line with regulation requirements.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures required action as five policies in the centre were out of date and required to be reviewed and updated in accordance with best practice.

Judgment: Substantially compliant

Quality and safety

Although residents spoken with were mostly content in the centre and satisfied with the service provided, the inspector found that action by the provider was necessary to ensure that there was effective oversight of residents care delivery and restrictive practice measures in the centre. These findings will be further detailed under the relevant regulations of this report.

Residents were provided with appropriate and timely access to their general practitioner (GP) services. Arrangements were in place for residents to access the expertise of health and social care professionals such as dietetic services, speech and language, physiotherapy and occupational therapy, through a system of referral. Wound care practices within the centre were reviewed and were found to be in line with evidenced based care.

The inspector reviewed a sample of residents' care records. Records showed that nursing staff used validated assessment tools to carry out assessments of residents' needs on admission to the centre. These assessments included the risk of falls, malnutrition, and assessment of cognition and dependency levels. Care plans reviewed by the inspector were of a good standard and included sufficient up to date information in relation to residents' current needs.

There were arrangements in place to monitor residents at risk of malnutrition. This included maintaining food intake records, weekly weights and timely referrals to dietetic and speech and language services, to ensure best outcomes for residents.

A policy was available to guide staff on management of and use of restrictive practices in the centre and up to date training was observed for all staff. However, where restraint was used it was found that associated documentation and risk assessment processes were not always followed and the least restrictive option was

not always used. These findings are actioned under Regulation 7: managing behaviour that is challenging.

Residents had access to media such as radio, television and internet services in the centre. A review of documentation evidenced that there was also an opportunity for residents to be consulted about, and participate in, the organisation of the designated centre by participating in resident meetings. The inspector reviewed records of resident and relative committee meetings which were held regularly in the centre and an action plan was developed for any agenda items of concern.

A robust activities programme was in place in the centre. The activities programme was in place until 8pm in the evenings, seven days per week and many residents were observed sitting relaxing, chatting and making jigsaws into the evening of the first day of inspection prior to retiring to their rooms as per their preference.

Ongoing upgrading of flooring in bedrooms was observed, however, the corridor floors particularly in Dinish unit were very scuffed and marked and required attention. Televisions in four bedded rooms particularly were placed high up over the door frames of the rooms and residents found it hard to look up at them especially those in bed spaces near the door. This is further detailed under Regulation 17: premises.

Regulation 11: Visits

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 12: Personal possessions

There was adequate space for residents to store their possessions, and clothes were laundered regularly and returned to the resident.

Judgment: Compliant

Regulation 17: Premises

While generally the centre was well-maintained, there were some areas that required maintenance attention. For example:

- Television screens in four bedded rooms were high over the door of the room and were difficult to watch. Two residents preferred to listen to the television as they were "very high up".
- While there was upgrades to flooring in the centre since the last inspection, the corridor flooring in Dinish unit was heavily stained and marked which could not assure adequate cleaning.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents informed the inspectors that there was "great improvements" in the food service in the centre. The newly refurbished kitchen was providing residents with a choice of meals, and an array of freshly baked scones and cakes were offered daily. Modified dietary requirements for some residents were appropriately appetising to ensure residents enjoyed their meal. There were clear systems in place to communicate residents' preferences and specific dietary requirements.

On the days of the inspection, the centre was very warm from the increase in temperatures; staff were observed providing residents with lots of refreshments and ice cream to ensure they were adequately cool and hydrated.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of care plans were reviewed in the centre. Residents care plans were developed following assessment, using validated assessment tools and were very person centred. Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs.

Judgment: Compliant

Regulation 6: Health care

Residents had very good access to medical assessment and review by their General Practitioner (GP). A range of allied health professionals were also available to residents such as physiotherapy, Occupational therapy, Speech and Language and

Dietetics. Evidence of ongoing referral and consultation was observed in care files for those who were referred to these services.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Where restrictive practice measures were in place, such as the usage of bedrails, the inspector was not assured that residents were appropriately assessed in line with national policy. For example:

- one resident who was admitted on the first day of the inspection had bedrails immediately placed around them without assessment or signed consent. The next day of the inspection post assessment, the resident was provided with a low bed and did not require bedrails. This initial finding was not in line with the centres policy on restrictive practice.
- one resident who had a bedrail assessment , was noted as requiring enabling (half) bedrails at their request at night time. The risk assessment detailed how the resident would be at risk of coming out over full bedrails if they were placed. On observation, the inspector found that the resident had full bedrails placed by staff which was not the assessed directive from the residents care plan.
- The restrictive practice register maintained in the centre was not accurately reflective of the level of restrictive practice measures in place on the days of the inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

Meaningful activities were available to residents in the centre. A team of two activities coordinators and an Occupational therapy assistant ensured residents were offered plentiful social and physical activities such as painting, gardening, exercise programmes and music therapy. Residents' meeting minutes were reviewed and any concerns identified were actioned and updates given to residents regarding same. Residents were supported to maintain their links to family, friends and the community.

Residents had an opportunity to participate in shopping trips, coffee shop dates and there were family days organised by the centre to ensure the residents had ample social engagement opportunities both inside and outside of the designated centre.

Independent advocacy arrangements were available also at the centre for those who require it.

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	
Registration Regulation 6: Changes to information supplied for registration purposes	Compliant
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Tralee Community Nursing Unit OSV-0000566

Inspection ID: MON-0048875

Date of inspection: 14/07/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Person in Charge (PIC) will ensure that regular agency staff are utilised where required to support continuity of care and maintain a high-quality service for residents. Nursing management will monitor skill mix during roster planning and ensure agency staff are allocated alongside permanent staff to provide appropriate supervision, support, and oversight. The PIC will ensure that all medication-related incidents are reviewed promptly, with Quality Improvement Plans (QIPs) implemented, monitored, and evaluated to reduce the risk of recurrence. An Agency Staff Induction and Accountability Checklist has been introduced to ensure agency personnel are familiar with their roles, responsibilities, resident needs, and local policies and procedures. The PIC will continue to engage with senior management regarding vacant posts, monitor recruitment progress, and escalate workforce requirements as necessary to ensure safe staffing levels and the delivery of a continuous, high-quality service. The PPIM and PIC has confirmed that recruitment approval for vacant posts will be progressed through the relevant approval pathways to ensure sustainable staffing levels within the unit. Staffing resources will be reviewed on an ongoing basis, including an assessment of vacancies and the requirement for additional posts to support residents with complex needs. Any identified requirements will be escalated through the management structure for approval and recruitment.	

Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has ensured regular supervision and oversight of mealtime practices. The PIC and CNM2 monitor the mealtime experience through ongoing observation to promote a positive, person-centred dining environment. The PIC has ensured that catering staff do not leave meal trays with residents who require assistance at mealtimes. Appropriate support is provided to residents in line with their assessed needs. The PIC has implemented measures to enhance the social dining experience, including the preparation of dining areas with appropriate cutlery and the provision of refreshments prior to mealtimes. Improving the mealtime experience has been identified as a quality improvement initiative and will be overseen through the local Food and Nutrition Committee. Progress will be reviewed at the next committee meeting scheduled for September 2026. For residents who choose to remain in the dining room after meals, the PIC has liaised with staff and the Activities Coordinator to ensure opportunities are provided to encourage participation in social activities and to promote the use of communal areas, in line with residents' preferences and choices. The PIC has reinforced with staff the importance of completing and reviewing risk assessments before implementing any restrictive practice within the centre. The PIC has ensured that the Restrictive Practice Register is maintained accurately and reflects current practices within the centre. The PIC and CNM2 provide ongoing oversight of restrictive practices and ensure these are reviewed at regular intervals to support the least restrictive approach and promote residents' rights, choice, and independence.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC and CNM2 have implemented a system to ensure sufficient staff are available to assist residents at mealtimes. Ongoing supervision and monitoring of mealtime practices	

will be undertaken to promote a positive dining experience and ensure residents receive person-centred support in line with their assessed needs.

The PIC has updated the local policy folder in line with guidance and updates received from Practice Development. A schedule for regular policy review has been established to ensure all policies remain current and accessible to staff. The Admission and Discharge Policy is currently under review by the Local Clinical Support Team (LCST) and will be discussed at the Quality and Patient Safety (QPS) Committee meeting on 18 August 2026.

A local Falls Prevention Group has been established and is led by the Rehabilitation Coordinator. As part of this initiative, a chair-based exercise program has been introduced with input from Physiotherapy and Occupational Therapy services to support residents' mobility, strength, and balance.

A multidisciplinary Falls Prevention Committee will be established as a quality improvement initiative. Membership will include Physiotherapy, Occupational Therapy, Nursing Staff, and relevant multidisciplinary team members. The committee will review falls incidents, identify trends, implement preventative measures, and monitor outcomes to reduce falls risk and enhance resident safety.

Regional QPS meetings are in place to support the escalation, review, and shared learning of incidents within designated centres, ensuring effective governance and continuous quality improvement.

Regulation 4: Written policies and procedures	Substantially Compliant
---	-------------------------

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

The PIC has updated the centre's policy folder in line with guidance and revisions provided by the Practice Development Team. The PIC will maintain ongoing oversight of the policy review process and ensure that all policies available to staff are current, approved versions.

The Admission and Discharge Policy is currently awaiting review by the Local Clinical Support Team (LCST) and is scheduled for discussion at the Quality and Patient Safety (QPS) Committee meeting on 18 August 2026.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The PIC acknowledges that the televisions installed in the four-bedded rooms are positioned at a height that may impact residents' ability to view them comfortably. A review has identified that additional televisions are available in the communal sitting areas and the Rose Café, which are accessible to residents and visitors. The PIC has raised this issue with senior management and has requested the installation of an individual television or wall-mounted viewing device in each four-bedded room. Approval is currently pending. The PIC will continue to liaise with the Estates Department and external contractors regarding quotations, timelines, and implementation plans. The PIC has engaged with the Maintenance Department regarding the condition of the corridor flooring in Dinish Ward. Following assessment, replacement of the flooring has been identified as necessary. Quotations are currently being sought, and the project is awaiting approval from senior management. The PIC has met with the contract cleaning company supervisor to review floor-cleaning arrangements and ensure that cleaning schedules and processes are appropriate and effective. The contractor has also been requested to undertake regular audits to monitor standards and support the maintenance of a clean and safe environment for residents.	
Regulation 7: Managing behaviour that is challenging	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: The PIC has reinforced with all staff the requirement to complete and review an appropriate risk assessment prior to the implementation of any restrictive practice within the centre. This will ensure that restrictive practices are only used when clinically justified and in accordance with residents' assessed needs. The PIC has ensured that the Restrictive Practice Register is maintained accurately and reflects current practice within the designated centre. The register will be subject to ongoing monitoring to support effective governance and oversight. The PIC and CNM2 will provide ongoing oversight of restrictive practices and ensure regular reviews are undertaken to assess continued necessity, explore less restrictive alternatives, and promote residents' rights, dignity, choice, and independence. Responsive Behaviour Training has been scheduled for staff to enhance knowledge, skills, and confidence in supporting residents who may present with responsive or challenging behaviors. The training will promote person-centred approaches to care and support staff in implementing evidence-based strategies to manage behaviours	

effectively.

Improved staff knowledge and competency in the assessment and management of responsive behaviors will support the reduction and appropriate use of restrictive practices, ensuring interventions are proportionate, evidence-based, and focused on achieving the best outcomes for residents.

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	31/12/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/08/2026
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	31/03/2027
Regulation 23(1)(d)	The registered provider shall	Substantially Compliant	Yellow	15/11/2026

	ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	30/08/2026
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/07/2026