



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

Issued by the Chief Inspector

Name of designated centre:	Araglen House Nursing Home
Name of provider:	Araglen House Nursing Home Ltd
Address of centre:	Loumanagh, Boherbue, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	24 June 2026
Centre ID:	OSV-0000705
Fieldwork ID:	MON-0050905

About the designated centre

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

Araglen House Nursing Home is a purpose-built residential centre, with accommodation for 90 residents. The centre is located close to the village of Boherbue on landscaped grounds with ample parking. The centre provides long-term, short-term, convalescence and respite care to both female and male residents with 24 hour nursing care available. The centre is divided into five units, Orchid, Honeysuckle, Primrose, Daffodil and Bluebell. All of the bedrooms are en suite, single or double, with shower, toilet and wash hand basin. Bluebell is the designated dementia unit. It is self-contained with its own sitting and dining rooms. There are four large sitting rooms and four large dining rooms and other smaller communal rooms located throughout the centre. There is an oratory available for residents. Outdoor areas comprise of four large secure gardens and four well furnished courtyards. These are furnished with colourful, raised flower boxes and seating.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	90
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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
Wednesday 24 June 2026	09:00hrs to 17:00hrs	Ella Ferriter	Lead
Wednesday 24 June 2026	09:00hrs to 17:00hrs	Erica Mulvihill	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out by two inspectors, with a specific focus on adult safeguarding and the measures in place to protect residents from abuse. The inspectors arrived at the centre in the morning and, over the course of the day engaged with 24 residents and visitors to gain an insight into the lived experience of those residing in the centre. In addition to these conversations, the inspectors observed interactions between staff and residents and reviewed a range of relevant documentation. Feedback from residents was overwhelmingly positive. Residents described staff as "exceptionally kind" stating that they consistently felt well cared for. They characterised staff as polite and respectful and expressed satisfaction with their quality of life in the centre.

Araglen House nursing home provides long-term care for both male and female adults with a range of dependencies and needs. The centre is registered to accommodate up to 90 residents and was at full occupancy on the day of inspection. The centre is located on extensive, well-maintained grounds in the village of Boherbue in North Cork. The main entrance features a large, bright, and welcoming foyer, furnished with comfortable seating and enhanced by tasteful decor, including displays of historical memorabilia. Residents were observed using this space throughout the day to relax and socialise. They informed inspectors that they particularly enjoyed spending time in this area, listening to the radio, chatting to staff and visitors and reading the newspaper.

Inspectors observed that the centre was bright, airy, clean and decorated to a very high standard throughout. The internal design and layout supported residents to move around the premises with ease and independence. Wide corridors, adequate handrails, and appropriately placed comfortable seating in communal areas enhanced accessibility and promoted residents' mobility and comfort. Residents spoke very positively about their bedroom accommodation, describing it as comfortable and homely. Many bedrooms were observed to be personalised with residents' own belongings and items from home, which contributed to a familiar and individualised living environment for them. Inspectors saw that there was a building project being undertaken to the back of the premises at the time and from a review of residents' meetings and from discussions with residents it was evident that they were aware of this.

Residents were able to receive visitors in communal areas or in the privacy of their own bedrooms. On the day of inspection, multiple family members and friends were observed visiting residents. Inspectors spoke with ten visitors, who overall expressed satisfaction with the quality of care provided to their relatives living in the centre. There was an adequate choice of communal areas in the centre, which were observed to be well used by residents throughout the day. A quiet room and a large oratory provided peaceful spaces for residents and their families to relax, reflect, or pray if they wished. Residents also had access to enclosed garden areas, which were

well maintained and equipped with comfortable seating and gazebos. As this inspection took place on a bright warm day in June, residents were observed using the outdoor gardens and a lively music session was seen to take place on the afternoon of the inspection where approximately 35 residents attended.

Lunchtime was observed to be a sociable and relaxed experience, with the majority of residents choosing to dine in the communal dining rooms. Meals were freshly prepared on-site in the centre's kitchen, which was visible via a hatch in the dining room. Residents confirmed that they were offered a choice of both main course and dessert. On the day of inspection, the food served, appeared nutritious and appetising. A variety of drinks was available to residents at mealtimes and throughout the day. Staff were seen to provide assistance to residents in a discreet and respectful manner where required. The majority of residents spoke positively with inspectors about the quality, quantity, and variety of food provided, while a small number stated they would like options such as jacket potatoes and bacon cooked the traditional Irish way. The management team stated that this would be addressed following the inspection.

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Staff spoken with were clear on who to speak with should they have any concerns with regards resident's care. Residents confirmed to inspectors that they could retire to bed and get up when they choose and they called for assistance staff replied promptly. Residents were supported with access to a range of facilities for occupation and recreation in the centre. The provider employed two activity staff members who worked Monday to Friday from 9:00am to 5:00pm. Inspectors met with these staff and found them to be knowledgeable, committed, and familiar with residents' individual preferences and interests. However, inspectors found that activity opportunities for the majority of residents were limited until the afternoon. Arrangements were in place for a small number of residents to participate in one-to-one activities in the mornings. However, inspectors observed residents spending much of the morning in communal areas watching television or listening to the radio, with minimal structured activity or social stimulation available. Discussions with staff and residents found that the activity programme for residents did not commence until after 2pm. These findings are discussed further under Regulation 9: Residents' Rights.

Staff were observed throughout the day to be respectful, courteous, and attentive in their interactions with residents. Inspectors saw that residents' privacy and dignity were consistently respected and upheld. For example, staff were observed knocking on residents' doors before entering their rooms, demonstrating respect for resident's personal space. Where residents requested that their rooms be locked, these wishes were consistently respected, and residents held the keys to their rooms.

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 the quality and safety of the service being delivered.

Capacity and capability

The purpose of this inspection was to review the measures in place to safeguard residents living in the centre. Inspectors found that the governance and management systems in the centre supported the delivery of good clinical care, and residents reported a positive quality of life within the centre. However, inspectors identified that management systems with regards to complaints, statutory notifications and safeguarding incidents required action. These findings will be detailed under the relevant regulations of this report.

The registered provider of the centre is Araglen Nursing Home Limited, which is governed by two directors. One of the directors is actively involved in the day-to-day management of the centre and maintains a strong and consistent presence on site. There are clear lines of accountability at individual, team and organisational level so that all people working in the centre are aware of their responsibilities and their reporting structures.

The centre was managed by a suitably qualified person in charge, who held overall responsibility for the delivery of care and support to residents. The person in charge was supported by a clinical management team comprising two assistant directors of nursing and two clinical nurse managers. One of the assistant directors of nursing deputises for the person in charge in their absence, ensuring continuity of leadership and oversight. A team, including nurses, healthcare assistants, activities staff, catering, domestic, administrative, and maintenance personnel, contributed to the effective operation of the centre. In addition, the provider employed a Human Resources Manager and a Facilities Manager to support the operational management and oversight of the service. On the day of this inspection there were adequate staffing resources considering the size and layout of the centre.

On the day of the inspection, staffing levels were sufficient to meet the needs of residents living in the centre. A review of staff rosters confirmed that a nurse was on duty in each unit. Staff who spoke with inspectors demonstrated a good understanding of their responsibilities in safeguarding residents and reporting any issues to the management team. Training records showed that all staff had completed safeguarding and dementia training within the previous three years. In addition, the centre provided training in responsive behaviours and human rights, with many staff having completed this training within the same period.

Records were seen to be maintained and stored adequately and met legislative requirements. Records were made available to the inspectors who noted that they complied with Schedule 2, 3 and 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. For example, An Garda Síochána (police) vetting disclosures were in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. These records were available in the centre for each member of staff, as required under Schedule 2 of the regulations. Nurses' yearly registration details were also maintained for all

registered nurses. Although incident records were well maintained, the oversight of statutory notifications was not robust, to ensure they were all submitted to the Chief Inspector as required by the regulations, as detailed under Regulation 31.

A review of complaints records found that although the four complaints received since the previous inspection were managed as per the centres policy, inspectors noted that the management team were also recording concerns. On review of this documentation inspectors found that some of these issues did not have appropriate investigations, actions or learning outcomes in place and were not recognised as complaints or safeguarding concerns. This finding is actioned under Regulation 23: Governance and Management.

There were governance systems in place to monitor the effectiveness of care delivered to residents and to identify areas for improvement. This included the development of a schedule of audits for 2026. The annual review for 2025 was completed and was reviewed and a quality improvement plan was developed with actions required, leanings and improvements recorded. However, findings of this inspection were that some of the safeguarding systems in the centre required improvement, which is detailed under Regulation 8: Protection.

Regulation 15: Staffing

The inspectors reviewed the staff rotas and discussed staffing with the management team. Based on the individual and collectively assessed needs of the residents, and having regard for the layout of the centre, the inspectors found that the level of staffing was sufficient to ensure that care was attended to appropriately. A review of a sample of staff files evidenced that staff had the appropriate qualifications, and were registered with their respective professional bodies. The provider had ensured references were sought prior to commencing employment.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems to record and regularly monitor staff training in place which were found to be effective. From a safeguarding perspective the provider had ensured that all staff had access to relevant training modules. Staff received training on the management of restrictive practices and the management of responsive behaviours which supported staff in understanding how residents, particularly those living with dementia or other conditions, may communicate or express physical discomfort or distress related to their social or physical environment. Staff were seen to have access to the Health Act and relevant guidance, including National

Standards in Adult Safeguarding. Training in safeguarding of vulnerable adults was provided to all staff as required by the regulation.

Judgment: Compliant

Regulation 23: Governance and management

While the provider had multiple management systems in place to oversee the quality and safety of care further action was required evidenced by the following findings:

- The systems in place to oversee complaints in the centre were not sufficiently robust. Specifically, the management team addressed many issues raised to their attention under the category of concerns. However, a review of this documentation indicated that a number of these issues met the threshold of formal complaints, with some relating to safeguarding matters. As such, these concerns should have been managed and investigated in line with the centre's safeguarding policy.
- The oversight of incidents occurring in the centre was not robust and safeguarding investigations did not always follow a clear procedure and were not in line with the centres policy and guidelines on safeguarding. This is further detailed under Regulation 8 and 31.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge did not submit all required notifications to the Chief Inspector within the required time frames, as stipulated in Schedule 4 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. These related to safeguarding allegations and one unexpected death of a resident.

Judgment: Not compliant

Quality and safety

The purpose of this inspection, focused on adult safeguarding, was to review the quality of service being provided to residents and ensure they were being afforded a high-quality, safe service which protected them from all forms of abuse. This

inspection found that the provider had some arrangements to meet the safeguarding needs of each resident. Residents expressed satisfaction with the care and their life in the centre and it was evident their rights were supported and protected by kind and caring staff. However, findings of this inspection were that action was required in the safeguarding systems and that staff were equipped with the knowledge to implement safeguarding policies. These findings are further detailed under Regulation 8: Protection.

Good practice was observed in the area of care planning for residents. The inspectors reviewed a sample of electronic care plans and found that these were developed within 48 hours of residents' admission to the centre. Validated assessment tools were used to identify risks, including falls, pressure ulcers, and malnutrition, with care plans developed accordingly. Care plans were found to be person-centred and were reviewed and updated at a minimum of every four months. Records reviewed by inspectors also demonstrated that residents had timely access to medical care and to a range of health and social care professionals, including speech and language therapy and physiotherapy services. Residents were facilitated to communicate freely and their communication needs were seen to be outlined in their care plans. The inspector reviewed two safeguarding care plans and it was evident that appropriate safeguarding measures were put in place for the residents.

Some systems were in place to safeguard residents and protect them from abuse. Staff were required to undergo Garda (police) vetting prior to commencing employment in the centre. There were robust arrangements in place to safeguard residents' finances. The provider did not act as a pension agent for any residents living in the centre. A designated person was appointed to oversee and manage residents financial arrangements, such as invoicing. There was evidence that where residents required additional support in this area, advocacy services were sourced and arrangements put in place for them to visit the resident. However, a review of records, together with discussions with the person in charge, demonstrated that not all safeguarding incidents and allegations were investigated in accordance with the provider's own policy.

The centre had developed a policy outlining the use of restraint, with reference to the Department of Health (2011) Towards a Restraint-Free Environment. Where restrictive practices were in use, a review of a sample of care plans demonstrated that appropriate restraint assessments had been completed and care plans were developed accordingly. Where there was a safeguarding care plan in place the inspectors saw that the residents were made aware of all matters and of supports available to them, in a manner that accounts for their communication needs.

The provider had developed a risk management policy that safeguards residents. This risk management policy has arrangements for the identification, recording, investigation and learning from safeguarding incidents. The staff promoted positive risk-taking for residents and supported residents to understand the risks associated with their choices. Residents were involved in decision-making around risk management such as declining transfer to hospital for care.

Residents were actively encouraged to participate in the organisation of the designated centre through regular residents' meetings held every four months, as well as through the completion of feedback questionnaires and family surveys. This ensured that their views were heard, valued, and taken into account in the running of the home. Residents could communicate freely and had access to telephones and Internet services throughout the centre. Residents also had access to independent advocacy services. Residents were encouraged to live meaningful lives in the centre and to go out with family and friends.

Regulation 10: Communication difficulties

Inspectors found that residents with communication difficulties had their needs comprehensively assessed and clearly documented within their care plans. Residents were supported to access appropriate communication aids and resources, such as Google translate, and communication boards were available and used to support residents with communication difficulties. This ensured they could communicate effectively and participate fully in daily life within the centre. Staff demonstrated a good understanding of each resident's individual communication requirements and were knowledgeable about the supports needed.

Judgment: Compliant

Regulation 17: Premises

Each bedroom, bathroom, and communal area was equipped with call bell facilities to enable residents to summon assistance from staff when required. Residents also had access to secure, locked storage, ensuring their money, personal documents and other possessions were safely safeguarded.

Judgment: Compliant

Regulation 26: Risk management

There was a risk management policy in place. This contained all information as set out in Schedule 5. The registered provider had ensured that there was a plan in place for responding to major incidents and serious disruption to essential services. The centre promoted a service which maximised residents' choices and control over their own lives while still protecting their safety as appropriate.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care records were maintained to a high standard. Comprehensive care plans were informed by validated risk assessment tools and were observed to be highly person-centred, reflecting residents' assessed needs, preferences, and wishes. There was evidence that care plans were reviewed at least every four months, or more frequently where required. Reviews were conducted in consultation with the resident and, where appropriate and with the resident's consent, their representative. This approach supported residents to actively participate in shared decision-making regarding their care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The use of bed rails as a restrictive intervention was kept to a minimum, with less restrictive alternatives, such as low beds and sensor mats implemented where appropriate. Restrictive practices were discussed at both governance and staff meetings, ensuring ongoing oversight and review. Risk assessments were completed, a restrictive practice register was maintained, and the use of restrictive practices was subject to regular review. Staff were provided with training in the management of responsive behaviors every two years.

Judgment: Compliant

Regulation 8: Protection

The inspectors was not assured that the registered provider had taken all reasonable measures to protect residents. For example:

- The registered provider had not recognised some allegations of neglect and omissions in care as safeguarding concerns, in line with the centre's own safeguarding policy. As a result, these allegations were managed through the complaints process rather than the safeguarding process. Consequently, the allegations were not subject to appropriate safeguarding investigations and did not result in adequate safeguarding actions, oversight, or learning outcomes to protect residents from the risk of further harm.
- Inspectors found that some investigations into safeguarding incidents had been delegated to the Assistant Director of Nursing. However, this was not in

accordance with the regulatory requirement which states that the Person in Charge is responsible for investigating incidents, allegations, or suspicions of abuse.

- While staff had completed safeguarding training, inspectors were not assured that the training had been effective in ensuring that staff and management could identify, respond to, and appropriately manage safeguarding concerns in practice. The provider assured the inspectors that a review of staff training would take place following the inspection to ensure that it was effective.
- A review of records relating to concerns reported found that four of these related to safeguarding. These had not been reported to the Chief inspector as required by the regulations and actioned under Regulation 31.

Judgment: Not compliant

Regulation 9: Residents' rights

Notwithstanding that residents were respected in the centre and had choice about their life, the social care needs of residents did not receive adequate attention to until after 2pm ensure that they were adequately stimulated and had variety to their day.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Araglen House Nursing Home OSV-0000705

Inspection ID: MON-0050905

Date of inspection: 24/06/2026

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All items/issues raised as concerns will now be categorised as complaints and will be investigated as per our complaints policy and if necessary, our safeguarding policy. A review of all incidents and complaints will be held monthly and will involve the Registered Provider Representative, the Person in Charge and the Assistant Director of Nursing who is the Complaints Officer. This will help to ensure that the centre's Safeguarding Policy is being appropriately followed.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All notifications will be submitted within the required timeframe as per Schedule 4 of the Health Act 2007 (Care & Welfare of Residents in Designated Centres for Older People Regulations 2013).	
Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Excluding those on maternity leave as of 28/8/26 96% of our staff have since the date of inspection received Safeguarding training from an external provider. Staff are now fully aware of what constitutes abuse. The feedback from this training has been positive and the Registered Provider expects that staff are now able to better recognise allegations of neglect and omissions of care as being safeguarding issues. The staff have been fully informed as to what steps to take if they do recognise allegations of neglect and omissions and most importantly whom they should report them to. Regular safeguarding drills will be held to help further reinforce this training and further familiarise staff in matters relating to safeguarding. The Registered Provider will take a zero-tolerance approach to abuse and will fully implement the disciplinary policy of Araglen House Nursing Home as necessary. All such allegations will now be managed through our safeguarding process. The first question to be asked following any incident or complaint will be "is this a safeguarding issue?" It is expected that with enhanced scrutiny of this process that learning outcomes will better protect residents. All investigations into safeguarding incidents will be investigated by the Person in Charge in line with the regulatory requirements. Since the date of inspection 96% of staff excluding those on Maternity Leave have completed Safeguarding training provided by an external provider. Feedback on this training has been positive. Weekly Safeguarding drills are now set to take place to further familiarise our staff with what constitutes a safeguarding issue. All concerns will now be treated as complaints and the first question to be asked regarding any complaint, or incident will be does this meet the criteria of a safeguarding issue. The onus will be on the Person in Charge to prove that it does/does not constitute a safeguarding issue. These matters will be strictly investigated as per Araglen House's safeguarding policy and procedure. Monthly review meetings between the Registered Provider Representative, the Person in Charge and the Director of Nursing who is the Complaints Officer will take place, and corrective actions will be taken as necessary. All safeguarding issues will be reported to the Chief Inspector as required by the regulations and will be actioned under Regulation 31.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights:	

The roster for both Activities Co-Ordinators has been changed to begin earlier and finish later and to operate 6 days per week. Activities commence at 9am and take place all day. Regular meetings with management are scheduled to take place.

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 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	25/08/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	25/08/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	28/08/2026
Regulation 8(3)	The person in charge shall	Not Compliant	Orange	28/08/2026

	investigate any incident or allegation of abuse.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	25/08/2026