



**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:	Athlunkard House Nursing Home
Name of provider:	Athlunkard Nursing Home Ltd
Address of centre:	Athlunkard, Westbury, Clare
Type of inspection:	Unannounced
Date of inspection:	11 May 2026
Centre ID:	OSV-0000729
Fieldwork ID:	MON-0049750

About the designated centre

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

Athlunkard House is a modern purpose built two-storey purpose nursing home. It can accommodate up to 103 residents. It is located in a residential area in Co. Clare on the outskirts of Limerick city. It is situated close to many amenities including St. Nicholas church and a local shopping centre. Athlunkard house accommodates 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, dementia care, physical and intellectual disabilities, palliative care, respite and post-operative care. Bedroom accommodation is provided on both floors in 89 single and seven twin bedrooms. All bedrooms have en suite bathroom facilities. There is a lift provided between floors. There is a variety of communal day spaces provided including a dining room, day room and visitors rooms provided on each floor. Residents also have access to two secure enclosed garden areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	85
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How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 11 May 2026	18:40hrs to 22:25hrs	Sean Ryan	Lead
Tuesday 12 May 2026	07:15hrs to 15:30hrs	Sean Ryan	Lead
Monday 11 May 2026	18:40hrs to 22:25hrs	Brid McGoldrick	Support
Tuesday 12 May 2026	07:15hrs to 15:30hrs	Brid McGoldrick	Support
Tuesday 12 May 2026	07:15hrs to 15:30hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

Residents living in Athlunkard House Nursing Home told inspectors that staff were kind, patient and supportive in assisting them with their daily routines and care needs, and that they felt safe living in the centre. Some residents described delays in receiving assistance, particularly at night, when requesting support to go to bed, and acknowledged that staff attended to them when they became available.

Inspectors arrived unannounced to the centre in the evening and met with the nurse in charge to obtain information regarding the residents living in the centre and the overall operation of the service, including any current infection prevention and control concerns or outbreaks within the centre. Inspectors completed a walk-through of the centre to observe the lived experience of residents and the quality of care and services being provided.

Some residents were receiving visitors in their bedrooms, where inspectors overheard laughter and conversation, while other residents were resting in bed. A number of residents spoke with inspectors about their experience of living in the centre. Overall, residents were very complimentary of the staff and described them as kind and caring. Residents said that staff would chat with them when they had time and would assist them, when requested. However, residents also described delays in receiving assistance due to staff being busy, particularly during the evening and night-time periods.

Some residents expressed concerns about other residents entering their bedrooms uninvited and stated that they were unsettled at times by hearing other residents calling out for assistance. Residents told inspectors that these situations were generally resolved once a staff became available to attend to residents. One resident told inspectors that a staff member had said they would return to assist them, but had not yet done so. The resident stated that this occasionally occurred and said that they would ring their call bell again to attract staff attention. Another resident was heard calling out for assistance from their bedroom. When inspectors met this resident, their call bell was not within reach and the resident requested assistance to get out of bed. A staff member who overheard the interaction subsequently attended to the resident. Inspectors observed that, some health care staff, responsible for responding to residents' care and support needs, were also required to undertake additional duties, including cleaning and washing up within the kitchen area.

Inspectors spent time observing the day rooms, where staff were allocated to provide supervision and support to residents. While these areas were generally supervised, inspectors observed that staff were not consistently engaging with residents. At times, changes in staff allocation resulted in staff members supervising residents who were unfamiliar with residents' individual care and support needs. Inspectors observed residents requesting assistance to go to bed. However, delays

occurred as staff relied on colleagues who were more familiar with residents' needs to return and provide this support.

Inspectors attended the handover meetings between day and night staff on both floors of the centre, where information relating to residents' nursing, health care and social care needs, including monitoring and observation requirements, was communicated to staff commencing duty. While these handovers were structured, health care staff were observed to respond to residents' supervision needs and call bells during this time. As a result, staff were absent from significant portions of the handover process and did not consistently receive key information regarding residents' care needs. Staff also confirmed that they did not routinely receive information relating to residents on other floors within the centre. Furthermore, household staff confirmed that they did not receive a handover.

Inspectors observed a number of fire safety concerns within the centre. This included faults displayed on the fire alarm panel and a number of fire doors appeared damaged or impaired in a manner that could compromise their effectiveness in the event of a fire emergency. Inspectors also observed inappropriate storage practices, including the storage of combustible items in areas that presented an increased fire safety risk. An internal smoking room was visibly unclean and was not maintained in a satisfactory condition over the two days of inspection. Ashtrays containing cigarette ends had been spilled and emptied onto the floor, with cigarette ends scattered throughout the room. Inspectors also found that the room was poorly ventilated.

A number of concerns relating to infection prevention and control practices within the centre were observed. Storage areas, the laundry and staff changing facilities were not maintained in a clean condition on the days of inspection. Inconsistencies were also observed in staff adherence to standard infection prevention and control precautions, including the appropriate use of personal protective equipment. In addition, a number of clinical hand wash sinks did not have suitable hand-drying facilities available for staff use. This meant that staff could not perform hand hygiene effectively and increased the risk of cross contamination.

Inspectors observed the dining room experience on both the ground and first floors of the centre. In general, staff were present and attentive to residents during mealtimes. Inspectors observed that meals were facilitated over two sittings to accommodate residents. However, inspectors observed that discussions between staff regarding the coordination and movement of residents through the dining rooms were carried out openly within residents' hearing, which did not support a dignified dining experience for residents.

Residents spoke positively about the support provided by staff with their personal care routines. Residents described how staff assisted them in choosing their clothes, getting ready in accordance with their personal style and preferences, applying jewellery and maintaining their bedrooms and personal spaces. Residents stated that some staff were particularly attentive to these aspects of their care, while other staff, although supportive, were not always able to provide the same level of personalised attention due to time constraints or when staff were absent. In

general, inspectors observed that residents were appropriately dressed and presented in accordance with their preferences. However, a number of residents appeared not to have received the same level of detailed attending to aspects of their personal care and grooming needs.

An activities programme was displayed on a notice board in the main reception area for residents to view. Residents told inspectors that they regularly participated in activities within the centre and described the staff facilitating activities as engaging and supportive in making the experience enjoyable. However, some residents felt that activities did not always reflect their individual preferences and interests, and that there was a greater focus on group activities rather than one-to-one engagement opportunities. Some residents spoke about preferences for more personalised activities, including access to particular entertainment choices. Residents stated that they intended to raise these suggestions at future resident meetings and commented that management were receptive to feedback and suggestions from residents regarding the quality of the service.

Visitors attending the centre throughout the day of the inspection were welcomed by staff. Residents and visitors were satisfied with the visiting arrangements in place. They confirmed that these arrangements were flexible. Residents said that they could spend time with visitors in communal areas or in the privacy of their bedroom. A number of visitors who spoke with the inspectors felt that their loved ones were well cared for in the nursing home and that they were kept up-to-date with any important changes to their care needs.

The next two sections of the report present the findings of this inspection in relation to capacity and capability of the provider, and how this impacts on the quality and safety of the service being delivered.

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). This inspection took place over two days in response to concerns received regarding the quality of care provided to residents and infection prevention and control management within the centre. As a result, there was a particular focus during this inspection on infection prevention and control measures and the systems in place to safeguard residents from the risk of infection. This information was substantiated on this inspection.

The findings of this inspection were that the governance and management of Athlunkard House Nursing Home had failed to meet the requirements of the regulations. A poorly defined organisational structure and ineffective management systems of monitoring and oversight impacted on the quality and safety of care

provided to residents. This was compounded by ineffective oversight and supervision across key aspects of residents' care and welfare, including clinical care practices, risk management, and the provision of appropriate person-centred care and support to meet residents assessed needs. Significant non-compliance was also identified in relation to the organisation and management of staffing resources, fire safety and the management of records. Inspectors also identified significant risks regarding the provider's oversight of infection prevention and control practices, specifically in relation to the management of an outbreak of infection within the centre. As a result of these concerns, the Chief Inspector issued an urgent compliance plan request to the provider following this inspection. The initial response did not provide the required assurance that the risks were being addressed. A warning meeting was held with the registered provider and a further opportunity was provided to respond to the urgent compliance plan request. A revised response was subsequently submitted on 29 May 2026, and accepted by the Chief Inspector, which provided assurance that the provider was taking action to address the identified risks.

Athlunkard Nursing Home Limited is the registered provider of Athlunkard House Nursing Home. It is a company consisting of four directors, one of whom represents the registered provider in communication with the Chief Inspector. The designated centre forms part of a wider organisational structure of Emeis, an organisation which operates a number of other designated centres throughout Ireland under different entities. A regional management structure was in place to support the designated centre and consisted of a regional director and associate regional director. The regional director was a person participating in the management of the centre and held direct responsibility for the governance, support and oversight of the service, including supporting the person in charge in the operational management of the centre.

The management structure within the centre consisted of a person in charge who was supported by an assistant director of nursing and a team of clinical nurse managers. However, there was a vacancy for an additional assistant director of nursing at the time of the inspection. This resulted in reduced management resources and gaps in the management structure which impacted on the monitoring, supervision and oversight of the quality and safety of care provided to residents.

While a management structure was in place within the centre, the registered provider had not ensured that there were clearly defined lines of accountability and responsibility across all areas of care provision, particularly in relation to the supervision and oversight of care delivery and infection prevention and control practices. For example, the centre had an active outbreak of infection at the time of this inspection. The arrangements in place to oversee infection prevention and control were ineffective, as appropriate outbreak control measures were not implemented or adequately monitored, resulting in residents not being adequately protected from the risk of infection. Additionally, inspectors found that the oversight and monitoring arrangements in place for the direct delivery of care to residents were ineffective. While responsibility for monitoring these aspects of care had been delegated to nurse managers, inspectors found that inadequate nutritional and fluid

intake was not being identified or appropriately responded to, and residents did not always receive personal care in line with their assessed needs and care plans.

The management systems did not ensure that all aspects of the service provided was safe, consistent and effectively monitored. The systems in place to monitor the quality of residents' clinical care and the physical environment were not fully or effectively implemented. For example, infection prevention and control audits covered a range of areas, including hand hygiene, equipment and environmental hygiene, and laundry management. However, recent completed audits reflected high levels of compliance and failed to identify the significant deficits in infection prevention and control observed during the inspection. This included the ineffective management of an outbreak and poor standards of environmental hygiene in ancillary storage areas. Consequently, no quality improvement plan was initiated or developed to address these issues.

While there was evidence that incidents involving residents were being documented and reviewed, there was inadequate documentation of some adverse incidents involving residents. A review of a resident's care file found information that was indicative of potential safeguarding concerns. The provider had failed to recognise a potential safeguarding incident and therefore, the incident was not documented, investigated in line with regulatory requirements or the centre's own safeguarding policy, or notified to the office of the Chief Inspector of Social Services.

The system in place to manage risk was not effectively implemented. Risks that had been identified by the provider were not managed in line with the centre's own risk management policy. For example, the centre experienced a period of unplanned staff leave. These vacant shifts were not covered, leaving the centre with inadequate staffing levels. The risk of lower staffing levels had not been assessed by the provider, and the decision not to replace absent staff was not informed by an evaluation of residents' dependency and care needs. This had a negative impact on the quality of care provided to residents.

Inspectors found that the absence of clear lines of accountability and responsibility extended to the management and oversight of the staffing resources within the centre. Oversight of staff rosters, staff skill-mix, allocation and supervision was ineffective, resulting in situations where management personnel were unable to confirm the rosters worked by staff, nor could they confirm if vacant shifts in planned staff rosters had been covered. Inspectors found that there was unclear delegation of responsibility and accountability for the daily allocation of staff and for ensuring appropriate staffing levels, staff composition and skill-mix were maintained. While inspectors were initially informed of vacancies in the health care assistant and housekeeping rosters, management had not identified additional unplanned leave affecting the nursing and laundry staff rosters. In addition, inspectors also found that staff had been assigned to work night-duty without having received an appropriate induction. This impacted on the quality and safety of the service provided to residents. This risk to residents was compounded by a lack of a clear procedure to monitor and escalate staffing deficits to the provider, or a pathway of action to manage unplanned staff leave.

While there were structured arrangements in place for staff handovers and the communication of clinical information between shifts, inspectors found that these systems were not effective. Staff were frequently required to leave the handovers to attend to residents' supervision and care needs, resulting in essential information, relevant to the delivery of safe, person-centred care, not consistently being communicated. This included information relating to the monitoring of residents' nutritional and fluid intake. Furthermore, inspectors found that information relating to an active outbreak in the centre had not been effectively communicated to staff, residents or visitors, either verbally or through written communication systems.

A review of the complaint management system found that complaints were not consistently recorded and managed in line with the centre's own policy and the requirements of the regulation. For example, complaints or expressions of dissatisfaction raised by residents during resident meetings, had not been documented, investigated or managed appropriately, in line with the complaints policy and procedure. Consequently, there was no plan in place to address the issues of concern.

A review of the centre's policies and procedures found that the registered provider had failed to ensure that policies were effectively implemented in practice. As a result, staff practices were not consistently guided by the provider's own governance and operational arrangements, which impacted on the quality, safety and oversight of the service provided to residents.

Inspectors found that the systems in place to supervise and support staff and oversee the delivery of direct care to residents were ineffective. Staff were not appropriately supervised to ensure care was delivered in accordance with residents' assessed needs and care plans. For example, a review of the arrangements in place for monitoring nutritional care identified that residents at risk of malnutrition and dehydration were not consistently receiving nutrition and hydration in line with their care plans. Inspectors also found that care records had been completed for residents who were not present in the centre at the time. Furthermore, nursing records did not identify or reflect these issues and, in some instances, recorded that residents had consumed adequate food and fluid intake, contrary to the residents intake monitoring charts. Overall, inspectors found there were ineffective monitoring, supervision and accountability arrangements in place to ensure the quality, accuracy and oversight of care delivery and associated records.

Regulation 15: Staffing

The provider had failed to ensure that there were sufficient staffing levels, with the an appropriate skill-mix, in the centre to meet the assessed needs of the residents, or for the size and layout of the centre. A review of the rosters found that there was inadequate staff available to meet the needs of residents, and for the size and layout of the centre.

- Staffing arrangements were inadequate at night-time to meet the needs of residents. Residents requesting support to go to bed experienced delays, as available staff were required to supervise residents in the day room and were unable to appropriately assist residents whose individual care needs they were not familiar with.
- Staff responsible for responding to residents' care and support needs were observed carrying out cleaning duties within the kitchen area during a time when residents in their bedrooms were calling out for assistance.
- Due to unplanned leave on the nursing staff roster, a nurse, responsible for the supervision and oversight of care delivery at night, was required to fill a vacant nursing shift at night. This reduced the effective supervision and coordination of staff within the centre during night-time hours.
- A review of staff rosters identified that unplanned leave, within the housekeeping and laundry departments, had not been replaced. As a result, both areas of the service were understaffed, which impacted on the effective implementation of infection prevention and control measures within the centre, and the laundry service provided to residents. There was significant uncertainty around the required staffing numbers needed to meet the needs of the service. The rosters reflected inconsistencies in staffing allocations, with fluctuations in the number of staff on duty, and no clear rationale for these variations. For example, inspectors were informed that short-notice unplanned staff leave did not require replacement due to current resident occupancy levels. However, staff responsible for the management of the rosters advised inspectors that these vacant shifts did require cover, but replacement staff had not been secured.
- Residents reported experiencing delays in receiving care and support, including assistance to go to bed and support with personal care needs. Residents stated that, while staff assisted them with personal care, care was delivered in a rushed manner and aspects of their care, including shaving and nail care, were not consistently completed.
- An assistant director of nursing position, a key management role responsible for governance and clinical oversight, was vacant and unfilled at the time of the inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised to carry out their duties to protect and promote the care and welfare of residents. This was evidenced by the registered provider's failure to;

- provide an appropriate level of staff supervision, monitoring and support to ensure that the health and social care needs of all residents were consistently met in a timely manner, and to ensure that the recommendations of allied health care professionals were implemented.

- ensure oversight of the residents' referrals to health care professionals and clinical documentation to ensure the assessment and care planning were accurate and up-to-date to reflect the current care needs of the residents.
- maintain accurate nursing care records to reflect the actual care provided to residents.
- provide effective supervision of staff to ensure residents received care and support in line with their assessed needs, including personal care, nutritional support, and pain management.
- provide appropriate supervision of staff to ensure that mealtime assistance was delivered in a manner that promoted residents' dignity, independence and person-centred care. Inspectors observed staff standing over residents while assisting them with meals, rather than supporting residents at eye level in a manner that encouraged more dignified and person-centred dining experience.

Judgment: Not compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements. For example;

- Records of specialist treatment, nutritional care and nursing care provided to residents were not accurately or appropriately maintained, in line with the requirements of Schedule 3(4)(b). Records of nutritional care provided to residents at risk of malnutrition were not maintained in line with the residents care plan. Records of residents locations, maintained for residents assessed as requiring high levels of supervision, were not accurately maintained.
- Staff rosters did not reflect the staffing levels on the days of inspection. Staff that were on unplanned leave from the centre were not identified as such on the planned or worked rosters provided to inspectors on the morning of the inspection.
- Incidents relating to residents' care and potential safeguarding issues were not documented or investigated in line with the requirements of Schedule 3(4)(j). This included the results of any investigation and the actions taken.
- A record of complaints, including any reviews of the complaints and the action taken by the registered provider in respect of any such complaints was not maintained in line with the requirements of Schedule 4(6).

Records were not maintained in a manner that was organised, accessible or readily available for review. Inspectors were required to make repeated requests for records throughout the inspection process, which demonstrated ineffective systems for the management, oversight and retrieval of records within the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that staffing resources within the centre were planned and managed effectively to support the delivery of person-centred, safe and consistent care to residents. Inspectors found that there were insufficient staffing resources available to respond to unplanned staff leave across nursing, health care, housekeeping and laundry rosters. While the provider reported the use of agency staff to support staffing deficits, agency personnel could not always be sourced to fill vacant shifts. This was further compounded by uncertainty among members of the management team regarding the appropriate staffing levels required to effectively operate the centre and ensure that residents' assessed care needs were met in a timely manner. In addition, inspectors found that the management and allocation of staff duties did not support the effective delivery of care. Health care staff were routinely assigned non-care duties, including cleaning and kitchen-related tasks, which reduced their availability to respond promptly to residents' care needs. The lack of effective oversight and management of staffing resources had a negative impact on the quality and safety of the service provided to residents.

The registered provider had not ensured that there was a clearly defined management structure in place, with clear lines of accountability and responsibility to support effective governance and oversight of the service. Inspectors found that the roles and responsibilities of members of the management team were unclear, particularly in relation to the oversight of key areas of the service, including infection prevention and control, staffing resources, delivery and oversight of resident's care, health care, risk management and complaints management. Consequently, the registered provider had not maintained effective governance and oversight arrangements to ensure these aspects of the service were appropriately monitored and managed. This impacted on the quality and safety of the service provided.

The poorly defined organisational structure impacted on the management systems in place to ensure the service provided was safe and appropriately monitored. This was evidenced by;

- A lack of effective oversight of the direct delivery of care to residents, including assessment, monitoring and ongoing management of residents care needs. This included the management and monitoring of residents experiencing pain, nutrition and hydration care, personal care, the management of environmental and clinical risks associated with residents at risk of absconding, and the implementation of appropriate control measures to ensure residents' safety.
- Poor oversight of infection prevention and control practices, specifically in relation to the management of an outbreak of infection within the centre.

Due to the risks identified in relation to the oversight and management of infection prevention and control and the ineffective oversight of residents' care needs and care delivery, an urgent compliance plan was requested from the provider to ensure

the protection of residents and to improve the safety and quality of care within the centre. The response received provided assurance that action was being taken to ensure that the identified risks were being adequately addressed.

In addition, the registered provider failed to ensure that the centre had adequate governance arrangements and effective management systems in place to ensure a safe, monitored and consistent service was provided. This was evidenced by;

- compliance plans submitted following previous inspections of the centre were either not implemented, found to be ineffective, or not sustained. This resulted in repeated non-compliance in multiple regulations, including governance and management, individual assessment and care planning, and the management of records.
- a failure to implement the centre's risk management systems to identify and respond to potential risks to residents. For example, despite concerns being raised about the quality of care provided to residents, there had been no assessment of work-force related risks, including staffing levels, staff training, supervision and the arrangements in place to ensure adequate oversight of care delivery. Furthermore, the provider had failed to implement policies and procedures designed to safeguard and protect residents.
- inadequate systems of communication to ensure all staff had information pertinent to providing residents with person-centred care. As a result, essential interventions and supports required to effectively meet those needs were not consistently communicated to staff or implemented, particularly in relation to residents at risk of malnutrition, dehydration and infection.
- ineffective systems in place to monitor and promote the well-being of residents through providing timely and appropriate referral to medical and health care services, and implementing the recommendations of health care professionals.
- poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation, care and treatment provided to residents, and records of staff rosters were poorly maintained.
- poor oversight of the complaints management system to ensure that complaints were appropriately documented, managed and investigated.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications were not always submitted to the Chief Inspector in line with the requirements of the regulations. An event that met the threshold for notification was not reported within the required time-frame.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of the complaint management system found that complaints were not always recorded and managed in line with the centre's own policy and the requirements of the regulation.

While documented complaints resulted in some actions being taken to address aspects of residents' care and the service provided, records did not consistently demonstrate that complaints had been comprehensively investigated. For example, where complaints had been received in relation to the quality of care provided to some residents, there was limited evidence to demonstrate that the underlying issues contributing to the concerns had been fully examined or that all corrective actions had been identified to prevent recurrence.

Complaints and expressions of dissatisfaction by residents in relation to food quality during resident meetings were not documented, investigated as complaints, or responded to, in line with the provider's complaints policy and procedure.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had failed to adopt and implement policies and procedures designed to support and protect residents. This included the policies in relation to;

- Risk management,
- Management of incidents and accidents,
- Staff training and development,
- The prevention, detection and response to abuse,
- The handling, investigation and review of complaints about any aspect of the service, care and treatment provided in, or on behalf of a designated centre,
- Infection control.

Judgment: Not compliant

Quality and safety

Inspectors found that aspects of the quality and safety of care provided to residents was impacted by inadequate governance and management arrangements described

under the Capacity and Capability section of this report. This inspection identified poor oversight and delivery of care, particularly in relation to residents' health care needs, assessments and care planning processes, and ensuring care was delivered in line with residents' assessed needs and care plans. Inspectors also found that residents' nutritional care needs were not consistently met. In addition, residents were not receiving care in an environment that adequately protected them from the risk of infection, and an urgent compliance plan request was issued to the provider following the inspection.

At the time of the inspection, an outbreak of infection was ongoing. Eight residents and 35 close contacts had been treated since the outbreak began in November 2025. Inspectors were informed that there were no symptomatic residents or staff on the day of the inspection. However, due to the long incubation period associated with this infection, it was too early to confirm that the outbreak was fully controlled. Furthermore, inspectors identified that there was no evidence of active surveillance of residents and staff for signs and symptoms consistent with this infection. These findings are set out under Regulation 27; Infection control.

Inspectors reviewed residents files in relation to the transfer of residents to and from the centre. The National Transfer Document and Health Profile for Residential Care Facilities was used when residents were transferred to acute care. This document was incorporated into an electronic care record and contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services. However, a review of files found that details of the ongoing outbreak in the centre was not included on transfer documentation. As a result, appropriate infection prevention and control measures may not have been put in place when residents were transferred to hospital.

The provider had committed to taking action to improve the quality of the nursing documentation with regard to the residents' individual assessment and care plans. While there was evidence that residents' needs had been assessed using validated assessment tools, the care plans reviewed were not always informed by these assessments, and did not reflect person-centred guidance on the current care needs of the residents. For example, care plans relating to wound management were inaccurate and did not reflect residents' current care needs. Inspectors also found that care was not always delivered in line with residents' care plans. For example, pain assessments were not always completed as required, and residents' fluid intake was not maintained, in line with their assessed needs and prescribed plans.

While there were arrangements in place for residents to access the expertise of other health care professionals, referrals for further expert assessment were not always completed in a timely manner. For example, a review of one residents file found that a resident had not been referred for further nutritional assessment following weight-loss and sustaining a pressure related injury, in line with the recommendation of a health care professional. In addition, inspectors found that the recommendations of health care professionals were not always implemented in practice.

A review of the nutritional aspects of the service found that the provider did not have robust arrangements in place to manage nutritional risk or monitor the nutritional care needs of residents. While nutritional screening was in place for all residents, the care pathway for residents assessed as being at risk of malnutrition was not consistently implemented. In addition, residents did not always receive nutritional care and support, in line with their nutritional care plans.

The protection of residents in the centre was underpinned by policies and procedures that set out the organisation's approach to safeguarding and protection of residents. However, this inspection found that the provider had not effectively implemented these policies and procedures in relation to the identification, investigation, and response to safeguarding concerns.

Inspectors reviewed aspects of fire safety arrangements within the centre and found that systems were in place for the servicing and maintenance of the fire detection and alarm system and emergency lighting. However, inspectors identified issues relating to the fire alarm panel, deficits relating to a number of fire doors which could impact on containment of fire, and concerns regarding the management of storage areas within the centre.

The premises were designed and laid out to meet the needs of the residents. Overall, the general environment including residents' bedrooms, communal areas and toilets appeared visibly clean and well-maintained. Ancillary facilities generally supported effective infection prevention and control. For example, staff had access to a dedicated housekeeping room in both floors for the storage and preparation of cleaning trolleys and equipment. Each unit also had a sluice room for the reprocessing of bedpans, urinals and commodes. However, storage areas, the laundry and staff changing rooms were not clean and were found to be poorly maintained. In addition, the purpose and function of a room was not in line with the statement of purpose.

Regulation 17: Premises

The provider had not ensured that the premises fully complied with the requirements of the regulations or that they were in accordance with the statement of purpose. For example:

- Discrepancies were noted between the floor plans, statement of purpose and what was observed on inspection. A room registered for use as a resident bedroom was being used as an office.
- Storage areas, particularly within the first floor of the cottage area of the centre, were poorly organised, cluttered and not maintained in a clean condition.
- Safe and suitable adaptations, such as window restrictors, within the premises were not appropriately maintained to ensure a safe environment for residents.

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 needs, including high-protein and high-calorie diets and specific food items to manage their weight, were not receiving diets in line with these recommendations. A number of residents continued to experience ongoing weight-loss following recent dietetic review and intervention.
- A number of residents were not receiving meals and food choices in line with their assessed preferences and care plans. Inspectors found that residents' identified food preferences, which had been outlined as a priority measure to support and encourage adequate nutritional intake, were not consistently provided. This information was not known to all staff preparing resident meals, or to the staff providing nutritional care to the residents.
- There was poor monitoring of residents' nutritional and fluid intake. Where residents' individual care plans specified nutritional and fluid intake to meet their assessed needs, these interventions were not consistently implemented. A review of monitoring records identified incomplete documentation, particularly where residents had not consumed meals or fluids, and there was no evidence that appropriate action had been taken in response to these concerns. In addition, not all residents had access to fresh drinking water at all times, as drinking water was not always positioned within reach of residents. Residents who were dependent on staff for assistance to access fluids did not have drinks readily available to them.
- Mealtime arrangements did not ensure that residents were provided with food at suitable intervals, as the evening meal was at 4.00pm and the next substantial meal was breakfast at 8.00am the following morning. While a tea trolley was available at 07.00pm, no substantial meal was provided during the intervening period.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not meet the requirements of Regulation 27: Infection control and the National Standards for infection prevention and control in community services

(2018). Inspectors identified a number of practices which may have contributed to the repeated outbreaks of infection within the designated centre. For example;

- There was no evidence that the provider continued with active surveillance of residents and staff for signs and symptoms consistent with infection, in line with Public Health guidance issued during the outbreak. This meant that new of recurring cases may not be identified promptly, increasing the risk of ongoing transmission within the centre and hindering effective outbreak control measures.
- There was some ambiguity about the status of the infection outbreak. An accurate line listing was not maintained, resulting in uncertainty among staff and management regarding the number of residents identified with infection to date.
- Staff informed inspectors that they manually decanted the contents of urinals into toilets prior to manually cleaning in resident sinks. This increased the risk of environmental contamination and the spread of health care associated infections (HCAIs).
- The provider had introduced a tagging system to identify equipment and areas that had been cleaned. However, this system had not been consistently implemented at the time of inspection. For example, several items of shared equipment had not been tagged after cleaning and the old tag was not removed after using some equipment.
- The laundry facility had a significant volume of used laundry awaiting washing, resulting in excessive build-up of dirty laundry in this area. This created a risk of cross infection, particularly in the context of the infection outbreak.
- Staff lockers were observed to be visibly unclean, with discarded items including tissues and personal protective equipment (PPE).
- Inappropriate use of PPE was observed during the course of the inspection which reduced the effectiveness of infection prevention and control measures.
- National guidance relating to infection prevention and control and outbreak management had not been effectively implemented in the management of an active infection outbreak. Inspectors found deficiencies in the communication, monitoring, and implementation of control measures to prevent the spread of infection, and staff were not aware of the measures required to manage the outbreak.

Due to the significant concerns identified regarding the management of infection prevention and control practices within the centre, including the management of an infection outbreak and the implementation of outbreak control measures, an urgent compliance plan was sought from the provider following this inspection. The response received provided adequate assurance that sufficient action was been taken to address the identified risks and protect residents from the risk of infection.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire precautions were not in compliance with the requirements of the regulations, as evidenced by the following findings identified during the inspection;

- The provider had failed to ensure that all staff responsible for the evacuation of residents in the event of a fire or emergency had received suitable training in fire prevention, emergency procedures and evacuation practices. Inspectors found that some staff had not participated in fire drills and, therefore, were not familiar with the procedures to be followed in the event of a fire emergency.
- A fault was displayed on the fire alarm panel at the time of inspection, and there was no clear time-frame for the resolution of this issue. There was no signage to alert staff of the fault and there was no communication to staff in relation to the fault.
- A number of fire doors, including cross compartment doors within the centre were observed to be impaired, which had the potential to compromise fire containment measures in the event of a fire emergency.
- Storage practices within the laundry area impacted the accessibility and effective use of double fire doors. Inspectors found that stored items in the laundry restricted the full opening of these doors.
- While emergency lighting was provided internally and externally at fire exits, there was insufficient illumination along external routes leading to the designated fire assembly point.
- Fire safety management and prevention measures within the smoking room were inadequate. The smoking room was not maintained in a satisfactory condition. Ashtrays were spilled and emptied onto the floor with ashes, cigarettes and tissue paper scattered throughout the area. This presented a potential fire risk.
- Combustible items were being inappropriately stored within the upstairs areas of a smaller building located to the front of the main centre. This included decorations, boxes of PPE supplied, and items used for residents recreational activities.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The registered provider had failed to take effective action to comply with the requirements of this regulation. For example;

- Care plans reviewed were not guided by a comprehensive assessment of the residents' care needs. For example, an appropriate care plan had not been developed for a resident who had experienced significant weight-loss and a

deterioration in their overall health condition. Consequently, staff did not have accurate information to guide the care to be provided to the resident.

- Care plans of several residents presenting with signs and symptoms of infection had not been updated to provide clear guidance on the required care and management.
- Care plans were not updated when a resident's condition changed. For example, where a resident had experienced a significant decline in oral intake, the residents care plan had not been updated to reflect this change or provide clear guidance to staff regarding the interventions and escalation measures required when the resident's nutritional and fluid intake was poor.

Judgment: Not compliant

Regulation 6: Health care

The registered provider failed to provide appropriate medical and health care including a high standard of evidence-based nursing care, in accordance with professional guidance. This is evidenced by a failure to;

- ensure arrangements were in place to implement the recommendations and interventions prescribed by health care professionals following expert assessment. For example, the recommendations made following assessment by dietitian and tissue viability nursing experts were not appropriately implemented. This included monitoring of residents nutritional intake, and ensuring appropriate management of a resident with impaired skin integrity. Inspectors also found that oral nutritional supplements recommended to support wound healing had not been provided in line with specialist recommendations.
- refer residents to an appropriate health care professional for further expert assessment, despite continued weight-loss, in line with the residents care plan or the directive of health care professionals that a referral should be made should weight-loss persist. In addition, there had been no review of a number of residents' weights following continued weight loss.
- The management of residents' pain was not consistent with a high-standard of evidenced-based care and was not always carried out in line with residents' care plans. In addition, inspectors found that some residents were not receiving adequate fluid intake to meet their assessed hydration needs.

Judgment: Not compliant

Regulation 8: Protection

The provider had not taken all reasonable measures to ensure residents were protected from the risk of abuse. This was evidenced by a failure to;

- ensure safeguarding plans, designed to safeguard and protect residents, were appropriately implemented. For example, residents who required enhanced levels of supervision to ensure their safety and the safety of others did not consistently receive this supervision.
- appropriately investigate potential safeguarding concerns. For example, the provider had been made aware of care incidents indicative of potential safeguarding issues. However, these incidents were neither managed or investigated in accordance with the centre's safeguarding policies and associated procedures.

Judgment: Not compliant

Regulation 9: Residents' rights

Not all residents were provided with adequate opportunities to participate in activities that reflected their individual capacities, interests and preferences. A number of residents told inspectors that, while activities were available, there was a strong emphasis on group activities and, as a result, they did not participate as the activities did not reflect their individual interests or abilities. Inspectors also observed that residents who chose to remain in their bedroom were not consistently provided with appropriate opportunities for social engagement or meaningful occupation.

Residents told inspectors that issues raised during resident forum meetings were not always responded to in a clear or meaningful manner. Residents stated that concerns raised at meetings often continued to be discussed at subsequent meetings, and they were unclear as to whether any action had been taken to address the issues identified. For example, concerns relating to food quality had been raised by residents on numerous occasions. However, there was no clear action plan or documented outcome outlining the action taken in response to the issues raised by residents.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Athlunkard House Nursing Home OSV-0000729

Inspection ID: MON-0049750

Date of inspection: 12/05/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of staffing levels, rostering, skill mix and deployment was completed across the centre to ensure that staffing arrangements are appropriate to the assessed needs and preferences of residents and the size and layout of the centre. This included a dependency versus occupancy review to determine the required staffing complement for all departments and shifts, including day and night duty. This is reviewed weekly- complete and ongoing A contingency plan has been developed to manage unplanned staff leave and unforeseen staffing shortages. This includes the use of additional agencies to ensure unplanned absence is addressed in all departments, including housekeeping. This has ensured that the rostered supernumerary supervision on both nights and days has been provided- complete and ongoing Robust absence management has reduced unplanned absence across departments and provided consistent staff numbers across all days, as per determined staffing needs- complete and ongoing From 18th May 2026, kitchen, laundry and domestic duties are managed through appropriate staffing in those departments to ensure healthcare assistants remain available for direct resident care. From 18th May 2026, all new staff receive specific training, supervised orientation and competency assessment before working night duty so that they are familiar with residents' support needs and required procedures. From the 18th May 2026, a staff allocation review was completed and staff training was delivered so that adequate supervision of communal areas is maintained while ensuring other staff are available to respond promptly to residents requiring assistance in their bedrooms. This also ensures resident personal hygiene is attended to effectively and in a	

person- centred and timely manner. Two CNMs are acting in the ADON role until the role is permanently filled. In addition, the associate regional director has been supernumerary 4 days per week in the home providing additional supervision and clinical support. Recruitment efforts continue and we anticipate that we will fill this post by 30th September 2026.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: There is a new Person in Charge in place since 13th July 2026- complete Since 18th May 2026, enhanced supervision and oversight has been in place in the home to include senior management governance reviews, weekly visits to the home and onsite supernumerary support from clinical managers. This included the Regional Director onsite 2 days a week, the Associate Regional Director onsite 4 days a week and the RPR onsite 1 day per week. Since 18th May 2026, arrangements to ensure consistent staffing levels have been in place which allowed rostered supernumerary clinical managers the time to supervise and oversee the provision of care to residents, in line with their assessed needs and preferences and the recommendations of the MDT. Since 18th May 2026, at least one management walkabout is documented daily to ensure that clinical supervision is effective in identifying areas for improvement, areas of good practices and actions taken to address issues identified. From 1st June 2026, CNMs have been allocated specific areas of responsibility, and this is overseen by the ADON and PIC to monitor resident assessments and referrals to healthcare professionals. This ensures referrals are made promptly, recommendations are implemented without delay, and outcomes are documented and reviewed. Oversight of this is in place monthly by the Regional Director and is also reported on a weekly KPI. Nursing documentation training has been refreshed with all nursing staff through staff meetings and audits to reinforce professional and regulatory requirements regarding accurate, contemporaneous and person-centred record keeping- complete From the 18th May 2026, daily clinical safety pauses and handovers have been enhanced to ensure residents requiring support with personal care, nutrition, hydration, pain management and other identified needs are clearly communicated and understood by staff.	

From 18th May 2026, daily care checks are completed by the CNM or senior HCA to confirm that personal care is delivered in line with residents' assessed needs and preferences and to record any exceptions. Where care is not delivered as required, this is addressed immediately through feedback, training, enhanced supervision and, where necessary, management or disciplinary escalation.

From 1st June 2026, the in-house management team also undertakes regular observational rounds to confirm that care is delivered in accordance with residents' assessed needs and care plans and takes immediate action to address any issues identified.

All staff have received guidance on best practice in supporting residents during mealtimes, with emphasis on dignity, respect, independence and person-centred care. Staff have been educated to provide assistance at eye level wherever possible, engage positively with residents during meals and promote independence in accordance with individual capabilities and preferences- complete

From 18th May to 21st August 2026, a daily mealtime observation audit was in place to confirm that residents receive appropriate assistance in line with their assessed needs and preferences, that meals are appropriate in terms of nutrition, modification and choice, and that individual care plans are followed. From 21st July 2026, this will be a weekly audit.

Staff supervision training was completed with nursing and care staff with our Senior Clinical Operations Manager and included a review of professional practice, documentation standards, implementation of care plans and adherence to allied health recommendations. Completed 1st July 2026.

Competency assessments have been completed for all clinical and care staff to ensure learning is embedded into everyday practice- completed

From 18 May 2026, all new staff receive specific training, supervised orientation and competency assessment before working night duty so that they are familiar with residents' support needs and required procedures.

Dignity and respect training has been provided for all staff - complete

From the 18th May 2026, a schedule of regular audits has been completed to monitor care planning, documentation, implementation of healthcare recommendations, mealtime practices and quality of care delivery. Audit findings, incidents and areas for improvement have been reviewed at weekly governance meetings, with action plans developed, monitored and evaluated to ensure sustained compliance.

Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All resident care records, including specialist treatment records, nutritional care records, nursing documentation (assessments, care plans and supervision records) were reviewed in June 2026 and are subject to ongoing review (weekly and monthly) to ensure that they are maintained that they accurately reflect the care provided and aligns with each resident's care plan - complete and ongoing From the 18th May 2026, resident location monitoring records for residents requiring enhanced supervision are reviewed daily to ensure accuracy, that they are contemporaneous and are reflective of care delivered. Staff supervision training was completed with nursing and care staff with our Senior Clinical Operations Manager and included a review of professional practice, documentation standards, implementation of care plans and adherence to allied health recommendations. Completed 1st July 2026. Any deficit identified in documentation through audits or daily reviews is addressed through immediate staff feedback, additional training where required and management escalation where there is a failure to deliver or document care in line with policy and residents' assessed needs- complete and ongoing. From the 13th May 2026, rosters are reviewed daily to ensure they accurately reflect staff working in the centre, any unplanned leave and these will be reviewed weekly by the PIC and Regional Directory to ensure compliance and accuracy. Training on incident reporting procedures and timely escalation of clinical issues including incidents and potential safeguarding concerns, was refreshed with all staff during safety pause meetings, staff meeting and the daily handover- complete From 1st June 2026, all reported and investigated incidents including potential safeguarding risks will include clear details of the event, comprehensive investigation findings, actions taken, outcomes and follow-up required. Safeguarding concerns as well as incidents are reviewed by the Regional team weekly to ensure appropriate and timely escalation and that investigation and learning outcomes are documented appropriately. The complaints log was reviewed and updated to ensure all required information is recorded. All complaints will include evidence of review, thorough investigation, response provided and actions implemented- complete and ongoing Staff have received refresher guidance on the complaints management process and the importance of recording feedback and outcomes. Complaints are currently reviewed weekly to identify themes and opportunities for improvement and to track implementation of agreed action plans- complete and ongoing A review of all records storage systems was completed to ensure documents are clearly organised and easily retrievable by all relevant staff- complete and ongoing	

From 1st June 2026, ongoing oversight of documentation systems will be conducted through regular audits, staff supervision, training and governance reviews. Any identified gaps will be addressed promptly, with actions documented and monitored to ensure sustained compliance with regulatory requirements.

Regulation 23: Governance and management

Not Compliant

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

A review of staffing levels, rostering, skill mix and deployment across the centre to ensure that staffing arrangements are appropriate to the assessed needs and preferences of residents and the size and layout of the centre. This included a dependency versus occupancy review to determine the required staffing complement for all departments and shifts, including day and night duty. This is reviewed weekly- complete and ongoing

A contingency plan has been developed to manage unplanned staff leave and unforeseen staffing shortages. This includes the use of additional agencies to ensure unplanned absence is addressed in all departments, including housekeeping. This has ensured that the rostered supernumerary supervision on both nights and days has been provided- complete

Robust absence management has reduced unplanned absence across departments and provided consistent staff numbers across all days, as per determined staffing needs- complete and ongoing

From 18th May 2026, kitchen, laundry and domestic duties will be managed through appropriate staffing in those departments to ensure healthcare assistants remain available for direct resident care.

From the 18th May 2026, an extensive recruitment drive has been completed to ensure there is adequate staff other than agency to fill the identified gaps and provide continuity to residents.

From 18th May 2026, daily staffing reviews will be completed by the clinical management team to ensure safe staffing levels are maintained.

From 13th July 2026, roles and responsibilities for the Person in Charge, management team and designated leads have been clearly defined.

From week commencing 1st June 2026, enhanced senior clinical oversight was introduced. This included initially one dedicated FTE Regional Director for the home, two experienced Clinical Nurse Managers from other homes rostered for four supernumerary shifts per week each for an initial four-week period. Continued oversight from the

existing Regional Director for at least one day per week, 4 days supernumerary onsite by the associate regional director and weekly onsite oversight by the Registered Provider Representative (RPR). These arrangements remain under weekly review in, line with governance and risk reviews and visits to the home.

From week commencing 18th May 2026, weekly clinical governance reviews have been established to review quality and safety indicators, regulatory compliance, incidents, risks, complaints and implementation of agreed actions. Meetings are documented and an action log and involve the Person in Charge/DON, ADON, Regional Director and additional senior oversight from a second Regional Director, Head of Quality and/or RPR as appropriate. The frequency of these reviews will move to fortnightly from 24th August 2026.

The DON, ADON, CNMs and staff nurses have received training on immediate escalation triggers, including unplanned staffing absence or changing resident needs, roster skill-mix concerns, clinical deterioration, safeguarding concerns, suspected outbreaks, absconding/elopement risk, audit results and actions not completed within agreed timeframes- complete

All resident care records, including specialist treatment records, nutritional care records, nursing documentation (assessments, care plans and supervision records) were reviewed in June 2026 and are subject to ongoing review (weekly and monthly) to ensure that they are maintained that they accurately reflect the care provided and aligns with each resident's care plan - complete and ongoing

From the 18th May 2026, resident location monitoring records for residents requiring enhanced supervision are reviewed daily to ensure accuracy, that they are contemporaneous and are reflective of care delivered.

Staff supervision training was completed with nursing and care staff with our Senior Clinical Operations Manager and included a review of professional practice, documentation standards, implementation of care plans and adherence to allied health recommendations. Completed 1st July 2026.

Any deficit identified in documentation through audits or daily reviews is addressed through immediate staff feedback, additional training where required and management escalation where there is a failure to deliver or document care in line with policy and residents' assessed needs- complete and ongoing.

From 18th May 2026, daily clinical handovers have been strengthened to ensure important resident information is communicated to all relevant staff.

From 1st June 2026, a system has been introduced to monitor referrals to medical and allied healthcare professionals and ensure recommendations are implemented and documented.

Care plan reviews will include evidence of evaluation and monitoring of outcomes. As part of enhanced governance oversight, random unannounced checks are completed at least weekly by the RPR, Head of Quality and/or a second Regional Director to provide assurance regarding dignity, privacy and the delivery of appropriate evidence-based care

in line with residents' assessed needs.

From 1st June 2026, the ADON is the designated Infection Prevention and Control Lead for the centre.

Infection prevention and control policies including outbreak management procedures have been refreshed with staff- completed.

Daily IPC specific walkabouts were conducted from 18th May 2026 to identify areas for potential improvement and learning. IPC audits will be completed monthly from 21st August 2026 as per our regular audit programme.

From 18th May 2026, workforce-related risks, including staffing levels, training, supervision and competency oversight, have been assessed and included within the risk register with controls added. These remain under regular review.

From 18th May 2026, resident-specific risks have been reviewed and updated in each individual residents' assessments and care plans, including risks relating to:

- Falls
- Nutrition and hydration
- Infection
- Absconding/elopement
- Behavioural support needs
- Pain management

Safeguarding policies and procedures have been reviewed, and staff have received refresher training to ensure that escalation is timely, investigation is thorough and learnings are shared to reduce risk of further occurrence- complete and ongoing

A review of documentation accessibility has ensured that all staff have appropriate access to the information they require to deliver safe and appropriate care, while maintaining confidentiality- complete

A structured handover system via a handover sheet to ensure essential information is communicated clearly at every shift change, including risk updates, monitoring requirements, and new interventions- complete

From 1st June 2026, catering staff now receive a consistent, standardised document daily to reflect resident requirements, choice and allergies. This is in addition to the resident food profile which is updated weekly or more frequently if resident needs change.

Healthcare assistant staff receive direct updates on dietary and nutritional risks at handover and safety pause to ensure appropriate response and adequate support at mealtimes and between meals to reduce risk of malnutrition or dehydration and to ensure adequate documentation of this- complete

Previous inspection action plans have been reviewed to identify barriers to sustained compliance- complete

Weekly governance reviews from 18th May 2026 reviewed the effectiveness of

implemented improvements and identified additional interventions. This will be held 2 weekly from 24th July 2026

The complaints log was reviewed and updated to ensure all required information is recorded. All complaints will include evidence of review, thorough investigation, response provided and actions implemented- complete and ongoing

Staff have received refresher training on the complaints management process and the importance of recording feedback and outcomes. Complaints are currently reviewed weekly to identify themes and opportunities for improvement and to track implementation of agreed action plans- complete and ongoing

A review of all records storage systems was completed to ensure documents are clearly organised and easily retrievable by all relevant staff- complete and ongoing

From 1st June 2026, ongoing oversight of documentation systems will be conducted through regular audits, staff supervision, training and governance reviews. Any identified gaps will be addressed promptly, with actions documented and monitored to ensure sustained compliance with regulatory requirements.

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The registered provider has strengthened systems to ensure that all regulatory notifications are appropriately identified, reviewed and submitted within the required timeframe. Effective oversight arrangements are now in place to promote timely reporting, accountability and compliance with regulatory requirements- complete

From 18th May 2026, the DON or deputy conducts a daily review of incidents and feedback, including information received from residents, representatives, MDT members and staff, to identify potential safeguarding concerns and any associated notification requirements. The Regional Director completes a monthly oversight review to identify trends, gaps in reporting or missed escalation and to ensure required notifications are submitted within the appropriate timeframe.

Staff have received refresher guidance on incident reporting processes and the importance of escalating events promptly to the Person in Charge- complete

Regulation 34: Complaints procedure	Not Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: From 13th May 2026, all complaints management, reviews, and investigations will be overseen by the Regional Director (RD) to ensure full compliance with our internal policy and governance standards. The complaint discussed on the day of inspection was specifically included in this review to identify opportunities for learning and improvement and to ensure that the matters raised were comprehensively investigated. Completed 30th May 2026 The complaints management policy and procedure has been reviewed to ensure it reflects current regulatory requirements and provides clear guidance on the management of complaints from receipt through to closure- complete From 18th May 2026, the complaints review process by the Regional Director ensures complaints relating to resident care are fully investigated, including examination of contributing factors, staff practices, care documentation and any relevant records. From the 18th May 2026, resident feedback, including food related concerns and concerns raised during resident meetings, will be formally recorded, reviewed and managed in line with the complaints process where dissatisfaction or concerns are expressed. Staff have received refresher training on recognising complaints, including verbal complaints, expressions of dissatisfaction and concerns raised informally by residents or representatives- completed From 13th July 2026, the Person in Charge will ensure all complaints are reviewed within appropriate timeframes and that complainants receive clear communication regarding outcomes and actions taken. A monthly audit of complaints' records to ensure compliance with regulatory requirements and the centre's complaints policy will be conducted by the Regional Director. This includes a review of complaint themes, trends and improvement actions and will be discussed at governance meetings monthly from 21st July 2026- complete and ongoing.	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: A review of the risk register has been completed to ensure all identified risks are appropriately assessed, managed and reviewed in line with agreed policies- complete	

and ongoing as risk are identified

Resident-specific risks and other risks, including staffing, environmental, clinical and operational risks, have been incorporated into ongoing risk monitoring processes. Clear responsibilities have been assigned for identifying, escalating and reviewing risks- complete

Nursing staff and clinical managers have received refresher training on incident reporting, escalation processes and documentation requirements. Completed 30th May 2026

All incidents are reviewed to identify contributing factors, required actions and learning opportunities, in line with agreed policies- completed

A review of staff training needs has been completed to ensure all staff receive appropriate training relevant to their roles and responsibilities and to ensure they deliver care in line with agreed policies- complete

The training matrix has been updated to monitor completion of mandatory and required training, specifically in relation to moving and handling. Supervision of moving and handling practices by the external trainer was introduced for a period of time to monitor staff knowledge following training- complete

From the 18th May 2026, staff competency assessments have been completed and supervision arrangements have been strengthened to support safe practice and to provide assurance that staff practice is in line with agreed policies and procedures.

From the 18th May 2026, all staff have had safeguarding knowledge assessments conducted to ensure understanding of our policy and actions required.

A monthly audit of complaints' records to ensure compliance with regulatory requirements and the centre's complaints policy will be conducted by the Regional Director. This includes a review of complaint themes, trends and improvement actions and will be discussed at governance meetings monthly from 21st July 2026- complete and ongoing.

Staff have received refresher training in infection prevention and control practices and skills assessments provide assurance that staff practices are in line with agreed policies- complete

Infection prevention audits are completed to review practice in line with policies, with findings documented and improvement actions monitored- complete and ongoing

Outbreak management procedures have been reviewed to ensure effective response, communication and oversight- complete

From 31st August 2026, compliance with policies will be monitored through regular audits, supervision and governance reviews.

From 31st August 2026, a monthly review of incidents, complaints, safeguarding

concerns and audit findings will be in place to ensure policies are effectively embedded into practice.

Regulation 17: Premises

Substantially Compliant

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

A review of the centre's Statement of Purpose, floor plans and actual use of rooms has been completed and updated floor plans were submitted on 17th August 2026.

An application to vary will be submitted by 31st August 2026, to reflect the changed use of the identified bedroom.

A review of storage areas, including the first floor of the adjoining cottage, was completed on 5 July 2026 to ensure all storage areas are clean, accessible and appropriately maintained.

A review of all safety adaptations within the centre has been completed, including exits, doors, windows, window restrictors and other environmental safety features- complete

25 new window restrictors were installed on the ground floor- complete

Any defective, missing or unsuitable safety adaptations have been repaired or replaced, staff training will be provided by 30th September 2026 to ensure any issues identified with safety equipment and environmental controls are reported promptly on our facilities management system.

From 18th May 2026, daily documented checks of alarms, locks, external lighting and access points were introduced. The Regional Director reviews the documented checks and undertakes a visual review at least weekly, with any identified deficit escalated and tracked to completion. From 21st July 2026, this will be incorporated into the daily management walkabout.

Premises' compliance and facilities management will be reviewed as part of the centre's governance and management meetings from 21st August 2026.

Regulation 18: Food and nutrition

Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

A review has been completed of all residents who have nutritional risks, recent weight loss, dietetic recommendations or prescribed therapeutic diets. Completed May 2026

Residents' care plans and dietary requirements have been updated to clearly identify individual nutritional needs, including high-protein, high-calorie and fortified diets, supplements, specific food requirements and any recommendations made by the dietitian or other healthcare professionals. All interventions and outcomes are documented within the resident's nursing and care records- Completed

Nursing and catering staff have been informed of these requirements, and an updated dietary information sheet is now in place to ensure that relevant information is available to all staff involved in the preparation and provision of meals. Completed

From 1st June 2026, catering staff now receive a consistent, standardised document daily to reflect resident requirements, choice and allergies. This is in addition to the resident food profile which is updated weekly or more frequently if resident needs change.

The monitoring of residents' food and fluid intake has been reviewed. Staff have been reminded of their responsibility to complete food and fluid monitoring records accurately and contemporaneously where these are required as part of a resident's care plan.

Nursing staff review these records daily. Where a resident has poor oral intake, refuses meals or fluids, or fails to achieve their identified nutritional or hydration requirements, this is escalated to the nurse in charge/DON- complete and ongoing.

Additional training and supervision has been provided to nursing, care and catering staff in relation to residents' nutritional and hydration needs, therapeutic diets, food fortification, individual preferences, completion of monitoring documentation and the escalation of concerns relating to poor nutritional or fluid intake- complete and ongoing

To strengthen governance and oversight, from 18th May 2026, a weekly nutrition review is conducted to review MUST scores, weight trends, fluid intake and dietitian recommendations.

From 18th May to 21st August 2026, a daily mealtime observation audit was in place to confirm that residents receive appropriate assistance in line with their assessed needs and preferences, that meals are appropriate in terms of nutrition, modification and choice, and that individual care plans are followed. From 21st July 2026, this will be a weekly audit.

Residents are offered a range of nutritious food choices during the evening, including sandwiches, toast, cereal, yoghurt, soup, fortified snacks and other preferred foods. Residents are also informed that food and drinks remain available outside scheduled mealtimes and can be requested at any time- complete and ongoing

Audit findings and actions are reviewed through governance arrangements, with any area of non-compliance addressed promptly- complete and ongoing

Regulation 27: Infection control	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: A comprehensive review of the current outbreak was undertaken immediately post inspection. The outbreak line listing was updated by 13th May 2026 to provide a clear and accurate record of the outbreak timeline and is maintained for all suspected and confirmed cases. Responsibility for maintaining and updating the line listing has been clearly assigned to the ADON/ clinical management team. A visit from the Public Health team was arranged for 21st May 2026 and no additional measures were required at that time. Active surveillance of all residents and staff for signs and symptoms of infection is now completed in accordance with Public Health and infection prevention and control guidance- complete and ongoing Surveillance documentation is reviewed as part of daily management oversight during an active outbreak. Any newly identified or suspected infection is escalated promptly to the Person in Charge (PIC), GP, Public Health and/or other relevant healthcare professionals as appropriate- complete and ongoing Clear communication arrangements are now in place so that staff, residents and visitors are informed of the current status of the outbreak and the control measures required. Visitor signage was updated and displayed at the entrance on 13th May 2026 and families were notified of the outbreak and are contacted as required regarding treatment needs or further updates. A Standard Operating Procedure was updated to set out the required outbreak actions, communication lines and documentation requirements in line with national guidance and Public Health advice. Staff education and awareness was reinforced through safety pauses and briefings. From 18th May 2026, a local outbreak control team was established in conjunction with Public Health, comprising the DON, IPC Lead, CNM, Regional Director, GP, Housekeeping and Laundry Supervisor and Senior HCA to oversee and coordinate outbreak responses and track implementation of control measures. Relevant resident care plans were updated to reflect infection history, and any resident identified with infection from 15th May 2026 has an individualised care plan setting out the required interventions- complete and ongoing From 18th May 2026, hospital transfer documentation includes relevant outbreak information to support continuity of care and reduce the risk of onward transmission. Staff have been instructed regarding appropriate decontamination practices for resident equipment. Our cleaning and tagging system has been reviewed and our agreed practice has been reinforced with all staff- complete and ongoing	

The accumulated used laundry identified during inspection was addressed immediately and laundry workflows have been reviewed to ensure that used/soiled laundry does not accumulate within the laundry facility. Clear separation between clean and dirty laundry is maintained at all times and responsibilities for monitoring laundry volumes and ensuring timely processing have been allocated to designated staff- complete and ongoing

Staff lockers and the surrounding staff facilities were cleaned and decluttered immediately following the inspection- complete

Staff received immediate refresher instruction regarding the correct selection, application, removal and disposal of PPE- complete

Daily IPC specific walkabouts were conducted from 18th May 2026 to identify areas for potential improvement and learning. IPC audits will be completed monthly from 21st August 2026 as per our regular audit programme.

IPC competency assessments commenced from 25th May 2026 to confirm that staff training was reflected in practice. Refresher training on PPE use, equipment decontamination and environmental hygiene was delivered by 28 May 2026. Training records and competency assessments are maintained, and any staff member requiring additional support receives further education, supervision and repeat competency assessment- complete and ongoing

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

A review of all staff fire safety training and participation in evacuation drills is underway and will be completed by the 31st August 2026.

Any staff member identified as not having participated in a fire drill has been prioritised for completion of a practical evacuation drill. A schedule of fire drills has been developed to ensure that all staff, including night staff and relief staff, participate in regular evacuation exercises and are familiar with the centre's emergency procedures, evacuation routes and resident-specific evacuation requirements by 30th September 2026.

The identified fault related to the dormant refuge call button/refuge phone and did not directly affect the operation of fire alarm panel. Walkie-talkies were available as an interim communication measure. The refuge button and link/refuge phone were fully replaced following the inspection- complete

From 13th July 2026, a system is in place to ensure that in the event of any fire-safety system fault, temporary signage will be displayed, and appropriate interim safety

measures will be implemented pending repair. The PIC will monitor outstanding maintenance issues to ensure that fire alarm faults are addressed within an appropriate timeframe.

A review of fire doors throughout the designated centre has been undertaken. Remedial adjustments have been completed on all bedroom doors and remaining door adjustments will be completed by 15th September 2026.

Routine fire door checks form part of the centre's ongoing fire safety monitoring programme. From 13th July 2026, any defects identified will be documented, risk assessed and escalated by the PIC for prompt repair- complete and ongoing

The laundry has been reorganised to ensure that fire doors, escape routes and access points remain unobstructed at all times- complete

Staff have been reminded that materials, equipment or supplies must not be stored in a manner that interferes with fire doors or escape routes. Compliance will be monitored through daily environmental checks and regular management walk-rounds- complete and ongoing

Repairs to external lighting was completed in car park area. A review of the adequacy of emergency external lighting to assembly points will be conducted and any improvements will be completed by 8th September 2026.

Immediate action was taken to clean and reorganise the smoking room following the inspection. Staff will carry out regular documented checks of the smoking room throughout the day to ensure that ashtrays are emptied safely, combustible waste is removed and the environment is maintained in a safe condition- complete and ongoing Residents who smoke will continue to have individual smoking risk assessments where required, and staff will monitor compliance with safe smoking practices.

A review of the storage arrangements was conducted within the upstairs storeroom following the inspection. All unnecessary combustible materials were removed and storage quantities were reduced. The area has been risk assessed. No flammable liquids, aerosols or other high-risk materials are stored within the room- complete

Regulation 5: Individual assessment and care plan	Not Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

Staff supervision training was completed with nursing and care staff with our Senior Clinical Operations Manager and included a review of professional practice,

documentation standards, conducting assessments, updating and implementation of care plans and adherence to allied health recommendations. Completed 1st July 2026.

All resident care records, including specialist treatment records, nutritional care records, nursing documentation (assessments, care plans and supervision records) were reviewed in June 2026 and are subject to ongoing review (weekly and monthly) to ensure that they are maintained that they accurately reflect the care provided and aligns with each resident's care plan - complete and ongoing

A review of residents' assessments and care plans has been completed to ensure they accurately reflect current needs and include all recommendations from allied health professionals. Completed 1st June 2026.

Residents' care plans and dietary requirements have been updated to clearly identify individual nutritional needs, including high-protein, high-calorie and fortified diets, supplements, specific food requirements and any recommendations made by the dietitian or other healthcare professionals. All interventions and outcomes are documented within the resident's nursing and care records- Completed

Relevant resident care plans were updated to reflect infection history, and any resident identified with infection from 15 May 2026 has an individualised care plan setting out the required interventions.

From 1st August 2026, care plans will be updated promptly following an identified change in condition and staff will not wait until the resident's scheduled care-plan review. Relevant changes and revised interventions will be communicated to staff through nursing handover and the resident's updated care documentation. Care plans have also been added to resident recording booklets for easy reference by all staff.

Regulation 6: Health care	Not Compliant
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Outline how you are going to come into compliance with Regulation 6: Health care:

A review of residents' assessments and care plans has been completed to ensure they accurately reflect current needs and include all recommendations from allied health professionals. Completed 1st June 2026.

All resident care records, including specialist treatment records, nutritional care records, nursing documentation (assessments, care plans and supervision records) were reviewed in June 2026 and are subject to ongoing review (weekly and monthly) to ensure that they are maintained and that they accurately reflect the care provided and align with each resident's care plan - complete and ongoing

A review has been completed of all residents who have nutritional risks, recent weight

loss, dietetic recommendations or prescribed therapeutic diets. Completed May 2026
From 1st July 2026, all residents who have been reviewed by dietitians, Tissue Viability Nurses (TVNs) or other healthcare professionals have had their recommendations reviewed by the nursing and management team.

Residents' care plans and dietary requirements have been updated to clearly identify individual nutritional needs, including high-protein, high-calorie and fortified diets, supplements, specific food requirements and any recommendations made by the dietitian or other healthcare professionals. All interventions and outcomes are documented within the resident's nursing and care records- Completed

Nursing staff have been refreshed on the need to ensure they document the implementation of specialist recommendations, including nutritional interventions, wound management plans, repositioning requirements, pressure-relieving equipment and prescribed monitoring to ensure adequate food and fluid intake monitoring and pain management- complete

From 18th May 2026, residents requiring nutritional monitoring have appropriate food and fluid intake charts commenced and maintained in accordance with their assessed needs.

From 1st July 2026, where oral nutritional supplements have been prescribed, all prescriptions and administration records have been reviewed to ensure supplements are available and administered at the recommended frequency.

Residents with impaired skin integrity have been reviewed to ensure wound assessments, wound care plans, dressing regimes, pressure-relieving measures and specialist recommendations are accurately implemented and documented- complete and ongoing

A structured review is in place for healthcare-professional recommendations, with clear allocation of responsibility, time-bound actions, evidence of completion and escalation where implementation is delayed- complete and ongoing

From 18 May 2026, residents prescribed pain relief or experiencing chronic or acute pain have pain assessments completed at a minimum of three times per day, in addition to assessment before and after administration of pain relief, to evaluate effectiveness and identify deterioration promptly.

From 18 May 2026, a review of residents with increased pain scores is undertaken to confirm the effectiveness of prescribed medication and optimise non-pharmacological interventions. Where pain remains uncontrolled or there is a change in presentation, staff are required to escalate promptly to the GP or appropriate healthcare professional.

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: All residents with identified safeguarding risks have been reviewed to ensure that current safeguarding plans and risk assessments are appropriate, up to date and fully implemented- complete Residents who require enhanced or increased supervision have been clearly identified. Their care plans and safeguarding plans now specify the level and frequency of supervision required, and staffing arrangements have been reviewed to ensure that this supervision is consistently provided- complete From 18th May 2026, a named CNM has responsibility for absconding/elopement risk oversight. A weekly review is completed for residents with identified absconding risk, including review of the environment, incidents, near misses and the effectiveness of mitigation measures. Staff have been briefed regarding residents requiring enhanced supervision, and this information is incorporated into daily handover and safety pause meeting to ensure continuity of care- complete and ongoing A retrospective review of complaints and incidents has been completed to identify any incidents that may represent a potential safeguarding concern. Where appropriate, safeguarding procedures have been initiated, including investigation, risk assessment, protective measures and referral/escalation in accordance with the centre's safeguarding policy- complete The centre's incident reporting and safeguarding procedures have been reinforced with all managers and staff. Staff have been reminded that any allegation, suspicion, disclosure, unexplained injury, concerning interaction or pattern of incidents that may indicate abuse must be immediately reported to the Person in Charge/designated safeguarding lead- complete Safeguarding concerns will be investigated promptly and comprehensively, with clear documentation of the concern, immediate protective measures, investigation undertaken, findings, actions implemented and outcome. By 1st June 2026, all staff have had a safeguarding knowledge/competency assessment completed, with particular emphasis on recognising indicators of abuse, reporting responsibilities, incident escalation, implementation of safeguarding plans and the management of resident-to-resident safeguarding risks. From 25th May 2026, staff education addressed immediate escalation triggers for changes in resident behaviour, environmental/security concerns or staffing issues that may increase absconding/elopement risk. The Regional Director completes a weekly review of safeguarding incidents and feedback to identify trends, increased risk or gaps in reporting, with additional oversight from the RPR/Head of Quality/second Regional Director as appropriate.	

Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents' care plans will be reviewed by 15th September 2026 and updated to clearly document their individual activity preferences and social engagement needs, including preferences for group activities, one-to-one activities and activities undertaken independently. This review will include involvement by residents and their nominated representative, where appropriate. The activity programme has been reviewed to ensure there is an appropriate balance between group and individualised activities, rather than relying predominantly on group-based activities- complete Activity and care staff will maintain records of activities offered, resident participation and reasons for non-participation. A quality improvement plan is in place to enhance this documentation further and will be complete by 30th September 2026. From 1st September 2026, the Person in Charge will review resident forum minutes and the associated action log monthly to ensure concerns are being responded to promptly, meaningfully and transparently. Effectiveness of these actions will be monitored through resident feedback, satisfaction surveys, activity audits, care-plan reviews and management oversight	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	30/09/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2026
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared	Substantially Compliant	Yellow	31/08/2026

	under Regulation 3.			
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	30/09/2026
Regulation 18(1)(a)	The person in charge shall ensure that each resident has access to a safe supply of fresh drinking water at all times.	Substantially Compliant	Yellow	18/05/2026
Regulation 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Not Compliant	Orange	18/05/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Orange	18/05/2026
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.	Not Compliant	Orange	18/05/2026

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	Orange	18/05/2026
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	18/05/2026
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	18/05/2026
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.	Not Compliant	Orange	01/07/2026
Regulation 21(6)	Records specified in paragraph (1)	Not Compliant	Orange	01/07/2026

	shall be kept in such manner as to be safe and accessible.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	18/05/2026
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 responsibilities for all areas of care provision.	Not Compliant	Orange	30/07/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	30/07/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the	Not Compliant	Red	19/05/2026

	standards published by the Authority are in place and are implemented by staff.			
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.	Not Compliant	Red	19/05/2026
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Not Compliant	Red	19/05/2026
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	18/05/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	08/09/2026

Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	13/07/2026
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.	Not Compliant	Orange	31/08/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be	Not Compliant	Orange	30/09/2026

	followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/09/2026
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	30/07/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/08/2026
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on	Not Compliant	Orange	31/08/2026

	the matters set out in Schedule 5.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/08/2026
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 concerned and where appropriate that resident's family.	Not Compliant	Orange	31/08/2026
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord	Not Compliant	Orange	31/07/2026

	Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(b)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the resident agrees to medical treatment recommended by the medical practitioner concerned, the recommended treatment.	Not Compliant	Orange	01/06/2026
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	01/06/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	18/05/2026
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	18/05/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to	Substantially Compliant	Yellow	30/09/2026

	participate in activities in accordance with their interests and capacities.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	30/09/2026