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:	CareChoice Macroom
Name of provider:	Carechoice (Macroom) Limited
Address of centre:	Gurteenroe, Macroom, Cork
Type of inspection:	Unannounced
Date of inspection:	13 January 2026
Centre ID:	OSV-0000209
Fieldwork ID:	MON-0048558

About the designated centre

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

Carechoice Macroom is set in the heart of Macroom. The centre provides long term care and respite care to older people. It is registered to provide nursing care to a maximum of 62 residents whose care dependency level range from supporting independent living to high dependency care. The premises has four floors, three of which are occupied by residents. Each floor is named after a location in the Macroom area. There are 42 single bedrooms and 10 twin bedrooms, the majority of which have en suite facilities. The centre has an elevator in the centre of the building. There are three dining rooms, three sitting rooms, an activities room and external courtyards off some of the communal spaces. CareChoice Macroom provides care primarily for dependent older persons, male and female, aged 65 years or over. The centre also provides care for dependent residents, male and female, under 65 years and over 18 years, this includes convalescent, dementia, palliative, and respite care. Care is provided by a team of nursing and care staff covering day and night shifts.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 13 January 2026	09:15hrs to 17:40hrs	Louise O'Hare	Lead
Tuesday 13 January 2026	09:15hrs to 17:40hrs	Ella Ferriter	Support

What residents told us and what inspectors observed

This was an unannounced inspection conducted over one day by two inspectors. Residents living in CareChoice Macroom told inspectors that they were content living in the centre, and they felt supported by staff. The inspectors greeted several residents throughout the day and spoke to 20 in more detail about their lived experience in the centre. Feedback was extremely positive, one resident told the inspectors that they would "give them a hundred points here", while another said they only had the best things to say about it, as they were always listened to by staff.

On arrival, inspectors conducted a walk around of the centre, followed by a meeting with the person in charge. This gave inspectors the opportunity to meet residents and staff as they went about their daily routine. The centre appeared calm and relaxed, and inspectors saw that many residents were having their breakfast in the centres' two dining rooms. Breakfast was served for residents in these rooms between 8am and 11am, and residents told inspectors they could come and be served at a time of their choosing and that staff always respected their choice with regards to what time they would like to get up. Inspectors saw that a staff member was attending to residents in each of these rooms and serving residents porridge, tea and toast. Residents met with in the dining rooms told inspectors they enjoyed this time of the morning. Some residents chose to remain in their bedrooms and this decision was always respected.

CareChoice Macroom is a four-storey premises, located in the heart of Macroom, which is registered for 62 residents. There were 58 residents living in the centre on the day of inspection. Residential accommodation is arranged over three floors and divided into four units, Bealick, Gearagh North and South, and Mountmassey. Bedroom accommodation is comprised of 39 single en-suite and 10 twin en-suite rooms, as well as three single rooms. Each bedroom door was designed to resemble the front door of a house, and were painted different colours, which can help residents to distinguish between rooms. Bedrooms were decorated nicely and personalised with photographs and other meaningful items. Each room had an activities schedule for the week displayed, as well as a menu of refreshments that were available during the day. However, inspectors noted that some twin bedrooms did not have a bedside locker for residents to store their belongings. This, and other findings, are discussed further under Regulation 17: Premises.

Communal areas were available for resident's use on each residential floor. The ground and first floor both had a dining room and lounge, with a multipurpose room also available on the first floor, with comfortable seating and tables, where residents could see and chat with the kitchen staff throughout the day. A small lounge was located on the second floor; however, inspectors were told that this was not used often and residents normally used the first floor communal areas instead. Inspectors noted that the centre was bright and well-decorated throughout. Although the

majority of the centre appeared clean and well maintained, some flooring in the communal spaces was noted to be visibly unclean. One resident also gave this feedback to inspectors. This finding is detailed under Regulation 27: Infection control.

An external courtyard was accessible through the first floor of the centre. The courtyard had a small smoking area and inspectors noted that the furnishings were not made of appropriate fire retardant material, as outlined under Regulation 28: Fire precautions. The inspectors were told that there was a plan of refurbishment underway for the centre. Three external doors had been recently replaced and there were planned upgrades for 19 bedrooms.

Notice boards with the planned activities for the week was displayed on two floors. Activities were scheduled seven days a week. Inspectors saw that mass was taking place at 11am on the day of the inspection in the sitting room on the first floor. The local priest informed the inspectors that he attended every Tuesday to say mass for the residents, many of whom were from the local area. Residents told inspectors that they looked forward to the weekly mass in the centre. In the afternoon, residents on the first floor were observed enjoying a singsong and playing bingo, while residents on the ground floor were engaged in quieter activities, such as crochet and chatting.

The inspectors spent time observing the dining experience for residents in both dining rooms. Lunch was served at 12.30pm and 1.00pm. Residents reported that they immensely enjoyed the food in the centre and that it was provided in sufficient quantities. Daily menus were displayed in suitable pictorial formats, and in appropriate locations, so that residents knew what was available at mealtimes. There was adequate numbers of staff available to assist residents with their meals. Assistance was offered discreetly, sensitively and individually. Residents spoke highly of the quality of food with one resident telling inspectors that meals were "like hotel dinners".

All residents who spoke with inspectors spoke positively of staff describing them as "kind", "lovely", and "good to chat." Call bells were seen to be answered promptly throughout the day of inspection. Residents told inspectors that staff were very good to provide them with care and assistance when needed, and that their choices and preferences were respected. It was evident that visiting was facilitated and inspectors met with six visitors over the course of the day. One visitor told the inspectors that staff were always quick to respond, and another that they were very approachable. Another visitor told inspectors that, while they were satisfied with the care given, they would like enhanced communication with nurse managers.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, this inspection found that CareChoice Macroom was a good centre with a strong management structure and that residents received a good standard of care. It was evident that the provider had taken a number of actions since the previous inspection to improve fire safety and infection control practices. However, further action was required in relation to records, premises, care planning, residents' rights, infection control and fire precautions. This inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, as amended, and to follow up on information received since the previous inspection.

CareChoice Macroom LTD is the registered provider for CareChoice Macroom, a designated centre primarily for older persons. The centre is part of the CareChoice group who operate fourteen centres nationally. The provider's representative is the chief executive officer and one of the board of directors. The management team had changed since the previous inspection, and a new person in charge and assistant director of nursing (ADON) had been appointed. The person in charge had been working full-time in the centre since September 2025. They demonstrated a good knowledge of their regulatory responsibilities. At an organisational level they were supported in their role by the senior management team, and on a day-to-day level they were supported by two ADONs as well as a team of staff nurses, healthcare assistants, activity coordinators, catering, housekeeping, administrative and maintenance staff. The regional operations manager for the group was available for consultation and support on a daily basis. The centre also benefited from access to a quality department, human resources, maintenance and facilities within the group. A human resources representative was based on site two days a week.

The inspectors saw evidence of good communication through regular safety huddles. Daily handovers of care took place to ensure staff were informed of the care needs of residents. Key clinical performance indicators on topics including wounds, infections and falls were collected to ensure the service was consistently monitored. A programme of audits was in place and the inspectors saw that these were analysed, with learning outcomes and action taken documented. However, some management systems required action as detailed in Regulation 23: Governance and Management.

Arrangements were in place for staff to raise concerns with management via staff meetings, minutes were seen by inspectors and it was evident that these took place biannually. The inspectors found that on the day of inspection there were sufficient staff to meet the assessed needs of residents in line with the centre's statement of purpose. Staff were seen to respond promptly to residents who called for assistance. From speaking to staff, and a review of records it was evident that staff had access to training appropriate to their role. Inspectors saw records which indicated that staff were largely up-to-date with mandatory training with a small number due to complete training the following week.

The inspectors followed up on the previous inspection of April 2025, which was undertaken by a specialist inspector in Fire and Estates. It was evident that the provider had acted on the majority of the findings as per this inspection, to improve fire safety in the centre and the outstanding items were planned for the coming months. The registered provider had also engaged an external fire consultant to review fire safety following this inspection, which evidenced good governance. This review also informed the centre's fire safety risk assessment. A programme of work had emerged from this assessment and the provider was working through the actions required.

Records were found to be stored adequately and were made available to inspectors as requested throughout the day. Records, as required to be maintained for each member of staff working in the centre, were available electronically. An Garda Síochána (police) vetting disclosures were in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. However, on review of a sample of staff files, inspectors found that references were not always obtained from the person's most recent employer, as required under Schedule 2 of the regulations. This, and other findings in relation to records, are further detailed under Regulation 21: Records.

There was a policy and procedure in place for the management of complaints. The procedure for making complaints was on display in the centre. Inspectors found that there was a comprehensive recording of complaints and incident records via an electronically maintained log. Incidents that required notification, as specified in Schedule 4 of the regulations, were submitted in writing to the Chief Inspector within the required time frame.

Regulation 14: Persons in charge

There was a change in person in charge since the previous inspection. The person in charge worked full-time in the centre, and had the knowledge, experience and qualifications as set out in the regulations. They had been in the post for four months at the time of this inspection.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that there was a sufficient number and skill mix of staff to meet the assessed needs of residents in the centre. On review of the staff rotas, the inspector saw that there was a minimum of two registered nurses rostered on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector saw records which indicated that staff were largely up-to-date with mandatory training. A small number of staff were booked to attend training in fire safety and managing responsive behaviour the week following this inspection.

Judgment: Compliant

Regulation 21: Records

Action was required to ensure that records were maintained in line with legislative requirements, evidenced by the following findings:

- Two staff personnel files reviewed did not have a reference obtained from the persons most recent employer. This was contrary to the centres policy on recruitment to ensure robust recruitment and protection of residents. This is also a requirement of the regulations.
- Records of nutritional care provided to a resident were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of a residents dietary intake were not always appropriately maintained for residents assessed as being at risk of malnutrition.

Judgment: Not compliant

Regulation 23: Governance and management

Although there was a strong management structure in place some management systems required action to ensure the service was safe, appropriate and effectively monitored, as evidenced by the following findings:

- Oversight of records in the centre was not robust. This was evidenced by two staff files not containing appropriate references, as required by the regulations as well as gaps in documentation of nutritional records and care plans, as detailed under Regulations 21 and 5.
- The oversight and monitoring of environmental cleaning required action as detailed under Regulation 27: Infection Control.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents were recorded appropriately and maintained in the centre. Notifiable incidents and quarterly reports had been provided in writing to the Chief Inspector, within the time frame required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Information posters on advocacy services, to support residents in making complaints, were on display in the centre. Residents and families stated they could raise a complaint with management and were confident in doing so if necessary. Details of the investigation, actions taken and the satisfaction or otherwise of the complainant was recorded. Complaints were discussed at management meetings and areas for improvement were actioned.

Judgment: Compliant

Regulation 4: Written policies and procedures

Schedule 5 written policies and procedures were available for review. They were updated as required, and in line with changes to the regulations.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents received a good standard of care and their rights and choices were respected in the centre. While a number of actions had been completed following previous inspections, some further actions were required in relation to care plans, infection control, fire precautions and residents' rights, as detailed under the relevant regulations.

Arrangements were in place to ensure that the transfer of residents from the designated centre to hospital, or other health care services, occurred in line with the requirements of the regulations. Residents' care plans and daily nursing notes were recorded on an electronic documentation system. An assessment of residents' health and social care needs was completed on admission and this ensured that residents' individual care and support needs were being identified and could be met. A review of a sample of resident care files found that assessments and care plans were completed within 48 hours of admission and reviewed four monthly, as per regulatory requirements. However, action was required to ensure that they were updated as needs of residents changed. These findings are further detailed under Regulation 5: Individual Assessment and Care planning.

The inspectors saw that safeguarding training was up-to-date for staff, and staff that spoke with inspectors were aware of their roles and responsibilities. Incidents or allegations of abuse were investigated by the person in charge, and the inspectors saw documentation that indicated learning from incidents were disseminated to staff.

Inspectors identified some examples of good practice in the prevention and control of infection. Infection prevention and control information and reminders were displayed on designated notice boards within the nursing offices. There were two cleaning staff on duty daily, allocated two units each within the centre. Staff members were knowledgeable about cleaning practices, processes and chemical use. However, findings of this inspection were that some further actions were required to ensure compliance with Regulation 27.

A review of fire precautions in the centre found that the provider had completed the majority of actions set out in the compliance plan submitted following the previous inspection. This included repairs and replacement of fire doors, addressing deficits in emergency lighting and enhanced fire drills. Fire doors were observed on the day of this inspection to function in line with their intended purpose to contain the spread of smoke and fire. Fire exits were unobstructed and were controlled through the fire alarm system to ensure they opened in the event of a fire emergency. Staff participated in fire evacuation drills monthly to ensure they were competent in the safe and timely evacuation of residents. Although it was evident that the provider had improved arrangements in place to monitor fire safety in the centre over the past six months some further actions were required as detailed under Regulation 28: Fire Precautions.

Overall, residents’ rights were respected in the centre and positive respectful interactions were seen between staff and residents. Residents had access to individual copies of local newspapers, radios, telephones and television. There was an activities programme available to residents seven days per week. A satisfaction survey had been completed for 2025 which evidenced overall satisfaction with the services provided in the centre. However, inspectors noted that there were a limited amount of residents' meetings taking place in the centre to ensure they were consulted with regularly, which is further detailed under Regulation 9: Residents Rights.

Regulation 17: Premises

Action was required to ensure that the premises conformed to Schedule 6, which included the following:

- In a number of twin rooms residents did not have access to a locker beside their bed. The provision of lockable storage for each resident is a requirement of the regulation.
- The curtains between residents' personal spaces in twin rooms did not always fully close, as this was being inhibited by wardrobes. This did not ensure that resident's privacy could always be maintained.
- Some flooring in the centre was observed to be damaged and torn.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were monitored for weight loss and were provided with access to dietetic, and speech and language services when required. Water and other refreshments were available for residents throughout the day. Food was freshly prepared in the centre's kitchen and was observed to be attractively presented, and a good choice was available. There were good systems in place within the centre to ensure that information with regards to residents' specific dietary requirements were communicated to the chef and kitchen assistants. This included written reports as well as morning briefings with heads of department to discuss the specific needs of residents.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Procedures had been established to ensure that the transfer of residents from the designated centre occurred in line with the requirements of the regulations. This included consultation with residents and their representatives regarding transfers and discharges, and arrangements to ensure information pertinent to the care of residents were communicated to the receiving health care facility. This is a completed action from the specialist infection control inspection of December 2024.

Judgment: Compliant

Regulation 27: Infection control

Action was required to ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services published by the Authority. This was evidenced by:

- Action was required in the overall standard of environmental cleaning. There was no routine deep cleaning schedule in place and inspectors were informed that deep cleaning was only undertaken following outbreaks or a resident discharge.
- Some areas of the premises on observation were visibly not clean, particularly some floors. This increased the risk of cross infection.
- There was a limited number of dedicated hand wash sinks in the centre, as found on inspection of December 2024.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Notwithstanding the work already completed and the proactive response to the findings of the inspection of May 2025, some further action is required to ensure the safety of residents living in the centre as outlined below:

- A small number of minor actions were required to complete work to the fire detection and alarm system to ensure that it provided the requisite L1 level of cover as recommended for Nursing Homes.
- Furniture in the external smoking area was not made of appropriate fire retardant material, to reduce the risk of fire.
- The provision of emergency lighting along external escape routes was not adequate to safely guide occupants from exits to place of safety. Inspectors were informed that there was plans for this work to be completed in the coming months.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While some care plans reviewed were person-centred and provided evidence-based guidance to support the current care needs of the residents, others required action as evidenced by the following findings:

- Where residents' risk of falls or malnutrition had increased, as per their individual assessment this was not always reflected in their care plan.
- A resident at end of life in the centre did not have sufficient detail in their care plan to guide care delivery. Specifically, there was limited individualised information in relation to physical, psychological, social and spiritual preferences.
- Where a resident required a care plan to support their current psychological condition, this was not initiated in a timely manner.
- Some information in care plans reviewed was outdated and related to care required two years ago. Therefore, this information was not relevant to the resident current health status and may result in confusion amongst staff or inaccurate care delivery.

Judgment: Substantially compliant

Regulation 6: Health care

There was a reported low incidence of pressure injuries sustained in the centre and the inspectors saw that the risk of same was assessed regularly and appropriate preventative interventions including pressure relieving equipment were in use. The inspectors reviewed the files of residents with wounds and noted adequate wound assessment and wound care charts in place. There was evidence of consultation with a tissue viability nurse when required.

Judgment: Compliant

Regulation 8: Protection

Safeguarding training was up-to-date for all staff and staff who spoke with the inspectors were aware of their responsibilities in reporting concerns. The inspector saw that allegations or incidents of abuse were investigated by the person in charge.

Judgment: Compliant

Regulation 9: Residents' rights

There was a lack of evidence that residents were adequately consulted about the day to day running of the centre. As per the centre's statement of purpose,

residents' meetings would take place in the centre every 12 weeks. However, inspectors found that only two meetings had taken place in 2025.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for CareChoice Macroom OSV-0000209

Inspection ID: MON-0048558

Date of inspection: 13/01/2026

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • An immediate review of all staff files has been completed. References from the most recent employers, where previously outstanding, have now been obtained and appropriately filed. A comprehensive audit of all recruitment documentation has also been undertaken to ensure full regulatory compliance. • The HR team utilises a recruitment checklist to ensure that all required documentation, including references from the most recent employer, is verified and in place prior to commencement of employment. Administrative staff have been reminded of regulatory requirements, and ongoing compliance will be monitored through regular audit and oversight processes. • The Director of Nursing (DON) will oversee compliance with this process to ensure adherence and prevent any recurrence. Nutritional Care and Documentation • A review of residents identified as risk of malnutrition has been completed by the clinical management team. Care plans, nutritional assessments, and monitoring records have been updated to accurately reflect residents' current needs and interventions. • Staff members are reminded during daily huddles of the significance of promptly and accurately documenting residents' food intake. • Nursing staff have received additional guidance regarding timely documentation, accurate recording of food and fluid intake, oversight of the HCA's touchcare entries and escalation processes where concerns are identified. • The Assistant Directors of Nursing will provide ongoing support, supervision, and refresher training to promote consistent practice. • Going forward, monthly audits of nutritional documentation and care planning will be undertaken. Audit findings will be reviewed at Clinical Governance Meetings to ensure sustained compliance and to support continuous quality improvement.	

Regulation 23: Governance and management	Substantially Compliant

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

Oversight of Records

• An immediate review of governance and oversight systems has been completed. All staff recruitment files have been audited, and required references have now been obtained and appropriately filed.

• A recruitment compliance checklist has been implemented to ensure all required documentation is verified prior to staff commencing employment.

• The HR team will conduct regular audits of staff files to maintain ongoing compliance. The Person in Charge will review audit findings as part of the centre's governance and quality assurance framework.

Nutritional Documentation

• Clinical oversight of residents' nutritional care and documentation has been strengthened. A review of residents identified as being at risk of malnutrition has been undertaken, and care plans and monitoring records have been updated where required.

• Additional guidance and supervision have been provided to nursing staff to support accurate, comprehensive, and timely documentation.

• Monthly audits of nutritional care and associated documentation will be implemented, with outcomes reviewed at Governance and Quality Meetings to ensure sustained compliance and continuous quality improvement.

Environmental Cleaning and Monitoring

• Oversight of environmental hygiene practices has been reviewed and strengthened. Updated cleaning schedules and monitoring tools have been introduced to ensure accountability, consistency, and clear lines of responsibility.

• The Person in Charge, supported by the Assistant Directors of Nursing, will conduct regular environmental walkabouts and hygiene audits to ensure standards are maintained.

• Audit findings will be reviewed through the centre's quality and safety governance structures to support ongoing monitoring and improvement.

These actions are designed to strengthen governance arrangements, enhance oversight of records and care practices, and ensure sustained regulatory compliance within the centre.

Regulation 17: Premises	Substantially Compliant

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

Bedside Lockers

• A review of all twin rooms has been completed to ensure each resident has access to

an individual bedside locker in line with regulatory requirements.
• Additional lockers have been sourced and will be installed where deficits were identified.
• All residents have access to lockable storage within their bedrooms.
• Ongoing environmental audits will incorporate checks to ensure appropriate furniture provision is maintained and remains compliant.
Privacy Curtains
• An assessment of the layout of twin rooms has been undertaken to ensure privacy curtains can extend fully and support residents' dignity and privacy.
• Wardrobes and furniture will be repositioned, where feasible, to facilitate full curtain extension.
• Where repositioning alone is insufficient, alternative curtain configurations and necessary adjustments to tracking systems will be scheduled and completed.
Flooring
• Damaged and worn flooring areas have been identified, logged with maintenance, and prioritised within the centre's repair schedule.
• Interim risk mitigation measures have been implemented to ensure resident safety pending permanent repair.
• A phased replacement plan is underway to ensure flooring throughout the centre remains safe, durable, cleanable, and fit for purpose.
Additionally, the Person in Charge will continue to monitor environmental standards through regular walkabouts, environmental audits, and maintenance reviews to ensure sustained compliance with Regulation 17 (Premises) and to promote a safe, comfortable, and dignified living environment for residents.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Environmental Cleaning Standards
• A full interior clean of the facility has been completed. In tandem, an immediate review of existing cleaning practices was undertaken.
• Enhanced daily cleaning schedules have been introduced, with clearly defined responsibilities and sign-off procedures to ensure accountability and traceability.
• Supervisory checks will be conducted by the Person in Charge (PIC), or delegated senior staff, to monitor and verify cleanliness standards throughout the centre.
Deep Cleaning Programme
• A structured deep cleaning schedule has been developed and implemented. This outline defined frequencies for high-risk and high-touch areas, residents' bedrooms, communal areas, sanitary facilities, and equipment.
• Records of completed deep cleaning tasks will be maintained and reviewed as part of the centre's Infection Prevention and Control (IPC) audit programme.
• Audit findings will inform ongoing quality improvement actions where required.

Hand Hygiene Facilities
• A full review of the premises was conducted to verify the availability of Clinical hand-washing sinks, and an environmental improvement plan is now in place to increase access to appropriate clinical hand hygiene facilities where feasible.
• In the interim, additional alcohol-based hand rub dispensers have been installed at key points throughout the centre. Staff have been reminded of best practice hand hygiene procedures in line with national IPC guidance.
• A risk assessment is in place to mitigate the potential risk of infection transmission where clinical hand-wash sinks are not available at the point of care.
Ongoing oversight by the IPC Link Nurse and the Person in Charge will be supported through regular environmental and IPC audits. Outcomes will be reviewed at Governance and Quality Meetings to ensure sustained improvement and compliance with Regulation 27 (Infection Control).

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Detection and Alarm System
• A competent fire safety contractor has been engaged to review the existing fire detection and alarm system. Works have been scheduled to address the identified gaps and to ensure the system achieves the required L1 level of coverage throughout the centre. Certification will be obtained upon completion, and ongoing servicing arrangements remain in place in line with regulatory requirements.

External Smoking Area
• The furniture previously located in the external smoking area has been reviewed. Non-compliant items have been removed and replaced with appropriate fire-retardant seating to minimise fire risk.
• Staff have been reminded of fire safety procedures and the need for regular monitoring of this area. A full flame-retardant apron for resident use is also available.
Emergency Lighting – External Escape Routes
• A review of emergency lighting along external escape routes has been completed. Additional emergency lighting has been commissioned to ensure safe illumination from exit points to designated places of safety.
• Interim control measures remain in place until installation is finalised, and functionality will be included in routine fire safety checks and maintenance schedules.
The Person in Charge will maintain oversight through regular fire safety audits and governance reviews to ensure sustained compliance with Regulation 28 and to support the ongoing safety of residents, staff, and visitors.

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

Care Plan Review and Updates

• An immediate review of care plans for residents identified during inspection has been completed. Care plans have been updated to accurately reflect current assessments, including risks relating to falls and malnutrition.

• Nursing staff have been reminded of the requirement to ensure that any change in assessment outcomes is promptly translated into updated, person-centred care plans.

• All care plans are reviewed at a minimum on a four monthly basis or on a change in the resident condition.

End-of-Life Care Planning

• The end-of-life care planning process has been reviewed. Guidance has been provided to nursing staff to ensure care plans clearly outline residents' wishes and preferences across physical, psychological, social, and spiritual domains to enable the resident to live as well as possible until they die and to die with dignity.

Psychological Support Care Planning

• Processes have been strengthened to ensure that where residents present with psychological or emotional needs, appropriate care plans are initiated without delay. The support plan is proportionate flexible, coordinated and adaptable to a resident's health condition, situation, care and support needs.

Removal of Outdated Information

• A full review of the resident's care planning documentation has commenced to identify and remove outdated or irrelevant information that may cause confusion for staff. Moving forward, monthly documentation audits will include a specific focus on ensuring care plans remain current, clear, and reflective of residents' present needs.

Additionally, the clinical management team will provide additional education for Nursing staff to ensure comprehensive and individualised care plan documentation is maintained. The Assistant Directors of Nursing will provide oversight and support to promote timely assessment and documentation through regular audits and spot checks

These measures are intended to strengthen clinical oversight, improve the quality and accuracy of care planning, and ensure residents receive safe, person-centred care in line with regulatory requirements.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents' Consultation and Participation • An immediate review of the schedule for residents' meetings has been completed. A resident had been scheduled for 14th January the day after the inspection and a further meeting has been scheduled to take place on 12th April 2026. The Annual meeting calendar has been implemented to ensure meetings occur at a minimum frequency of every 12 weeks, in line with the centre's Statement of Purpose. • The Person in Charge has assigned clear responsibility for the coordination, documentation, and follow-up of residents' meetings to ensure consistency, meaningful engagement, and appropriate action tracking. Improved Documentation and Evidence of Engagement • Templates for recording meeting minutes are available to ensure residents' feedback, suggestions, and concerns are clearly documented, with actions identified and reviewed at subsequent meetings. • Notice of meetings and minutes from the meetings are posted on the resident's information board and communicated to residents by the Activity Team. Alternative methods of consultation, including one-to-one discussions and feedback opportunities for residents who may not wish to attend group meetings, will also be captured to demonstrate inclusive engagement. Other formats organized to receive feedback from residents, and their family members, include the use of the following • Suggestion Box • Resident Satisfaction Survey Governance and Oversight • Compliance with the residents' meeting calendar will be overseen by the Governance Team and the Clinical Operations Director to ensure adherence and sustained regulatory compliance. • The PIC will provide oversight and support to ensure that meaningful consultation with residents is embedded into practice and that evidence of engagement is maintained. • The Person in Charge will review the minutes of the residents' meetings and will meet with any resident who raises any issues or concerns. These actions aim to strengthen residents' participation in the running of the centre and ensure ongoing compliance with Regulation 9.	

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 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/05/2026
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	28/02/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Substantially Compliant	Yellow	28/02/2026

	consistent and effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	28/02/2026
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.	Substantially Compliant	Yellow	31/03/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/05/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/05/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in	Substantially Compliant	Yellow	31/05/2026

	paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.			
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.	Substantially Compliant	Yellow	28/03/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Substantially Compliant	Yellow	31/01/2026