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:	Craddock House Nursing Home
Name of provider:	Werlay Limited
Address of centre:	Craddockstown Road, Naas, Kildare
Type of inspection:	Unannounced
Date of inspection:	10 June 2025
Centre ID:	OSV-0000027
Fieldwork ID:	MON-0047241

About the designated centre

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

Craddock House Nursing Home is purpose-built and was established in 1999. It is located on the outskirts of Naas town, close to the general hospital and across from a secondary school. Residents have good access to amenities and have a range of recreational activities within a warm, welcoming and friendly atmosphere. There is unrestricted access to colourfully planted, paved and secure courtyards with open and sheltered seating areas along with many tactile items, including water features. The large courtyard garden has covered seating. There is a small courtyard garden off Rose Cottage and two other garden areas for resident use. The nursing home provides 24-hour nursing care seven days per week and is designed to ensure the comfort and safety of residents in a home-like environment. The nursing home provides a respite service, residential and convalescent care. Male and female residents are primarily over 65 years of age. The home can accommodate 89 residents over two floors serviced by a passenger lift and stairwells. It comprises 77 single and six double/twin bedrooms. Most bedrooms have full en-suite facilities or shared bathrooms, and eight single bedrooms that have access to communal toilet and bathroom facilities within close proximity. There are three main day and dining areas, called The snug, The cosy corner and The relaxation room. There are two conservatories and a spacious reception area for residents to relax in. In addition to these, there are two administration offices and three nurses stations, a hairdressing salon that operates three days weekly, a spacious oratory where mass is celebrated weekly, the main kitchen that services the households and a spacious multi-purpose room for family functions, meetings and staff training. Separate and adjacent to the main building are the laundry, boiler room and additional administration offices. To the front of the building, there are ample car parking spaces.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	85

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 10 June 2025	08:05hrs to 17:00hrs	Aislinn Kenny	Lead
Tuesday 10 June 2025	08:05hrs to 17:00hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Overall, residents spoken with on the day of the inspection reported that they felt safe in the centre and that staff were kind and helpful while providing support.

Inspectors met with many residents during the inspection to gain insight into their experience of living in Craddock House Nursing Home and spoke more in-depth with eleven residents and five visitors. The overall feedback from residents and visitors was generally one of satisfaction with the quality of care in the centre however, residents said staff could be busy and at times they had to wait for their bell to be answered. Inspectors also observed that call-bell wait times for some residents during morning care were between ten and fifteen minutes. Inspectors identified that two residents call-bells were not working and one resident told inspectors they did not think their call-bell had ever worked.

The inspectors spoke with five visitors in detail about their experiences whilst visiting the centre. One visitor said that "communication with the management team had improved recently". Another visitor said that sometimes there was a long wait for call-bells to be answered, while another commented that the "staff had no name badges" and that it was "difficult to make connections and remember names easily". Despite this, the overall view was positive and that staff were very kind and gentle.

At the time of inspection, the centre was in an outbreak of COVID-19. During a walk around the centre inspectors observed Infection Prevention Control (IPC) practices and observed that some staff were not wearing masks or were not wearing them correctly. In addition, inspectors observed that not all residents were isolating in line with guidance, which posed a risk to the health and safety of staff, visitors and other residents.

The kitchen was being refurbished at the time of the inspection and residents' meals were being prepared in another designated centre and delivered to this centre. Residents' meal times were observed and residents were seen to be appropriately served despite the temporary kitchen arrangements. Residents were complimentary of the food and food preferences were frequently discussed at residents' meetings. Each unit had a kitchenette area that was used to serve breakfast to residents. Dinner was served from a bain-marie in these areas as a temporary measure. However, inspectors observed that shortly after breakfast time one staff member was assisting and supervising up to seventeen residents in Rose Cottage.

The premises was observed to be warm, comfortable and visibly clean on the day of the inspection. Inspectors observed that the registered provider had made improvements to the premises since the previous inspection and new floor covering and wall covering were seen on the first floor. The hairdressing room was clean and well-maintained and residents were seen getting their hair done on the day of the inspection.

A variety of communal areas were available for residents' use, including a day room, a dining room and a visitor's room. As it was National carers week the provider had organised gifts for staff in the centre and later in the afternoon an ice-cream van arrived to provide residents and staff with ice-cream cones. Areas of the centre were bright and nicely decorated and provided a nice environment for residents. An external courtyard was accessible from various parts of the building. The ancillary rooms generally supported infection prevention and control. There were two sluice rooms in the centre. Lily Valley Unit did not have a dedicated sluice room, however the residents in this part of the centre were lower dependency in terms of the need for a sluice room.

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

Capacity and capability

This was an unannounced inspection which took place over one day. Overall, improvements were found in the designated centre in relation to the upkeep and layout of the premises and medication management practices. However, on this inspection, the inspectors found significant risks to the care and welfare of the residents in respect of infection control and that prompt action was required by the registered provider to ensure that the governance and oversight was effective to safeguard the residents.

Werlay Limited is the registered provider for Craddock House Nursing Home. The company is a part of the Virtue Group which has a number of nursing homes nationally. There had been a change in the person in charge of the centre since the previous inspection. The person in charge reported to the project manager, who reported to a regional director. The person in charge worked full-time and was supported by a newly appointed assistant director of nursing, a clinical nurse manager, a team of nurses and healthcare assistants, an activities co-ordinator, catering, housekeeping, administration and maintenance staff. While supports were available from the regional manager, some gaps in oversight were evident as a result of a new and inexperienced management team in charge of the operational running of the centre at a time of refurbishment. The management presence in the centre had increased since the previous inspection and improvements were noted in some areas as a result of this. Notwithstanding, at the time of the inspection two clinical nurse manager roles were vacant; one role had been recruited to on a part-time basis and the provider had put in place contingency arrangements for a staff nurse to fulfill that role in the interim. Staff were observed attending to residents in a kind and respectful manner however, action was required to ensure there were adequate staffing levels in place to meet the needs of the residents living in the

centre. Residents told inspectors that at times they were waiting a long time for their call-bells to be answered and this was also observed on the day.

Systems were in place for the clinical oversight and operational management of the centre, however they needed to be strengthened. While call-bell audits were taking place, they had not identified delays to care. As a result there was no action or improvement plan in this respect. There were daily operational meetings held with the project manager and management team in the centre. However, further action was required on the oversight of IPC practices and staffing as outlined under Regulation 23: Governance and Management.

A review of staff training records found that staff had up-to-date mandatory training in fire safety, infection control, safeguarding of vulnerable people, and responsive behaviours. Notwithstanding, staff supervision required to be strengthened to ensure staff consistently implemented the principles of training in practice, specifically in respect of infection control.

An outbreak of COVID-19 had been declared in the designated centre on 27 May 2025. A total of 18 confirmed or suspected cases had been identified. The majority of residents and staff were recovering and were no longer symptomatic. This was the fourth outbreak of infection in the centre this year. While it may be impossible to prevent all outbreaks, appropriate and careful management can mitigate spread of infection and limit the impact of outbreaks on the delivery of care. The findings of this inspection were that the governance and management systems in the centre were not effective to manage the current outbreak. Inspectors found evidence of poor oversight of staff and staffing resources that was impacting on the quality and safety of residents.

Regulation 14: Persons in charge

The person in charge was a nurse working full-time in the centre and met the criteria of the regulations.

Judgment: Compliant

Regulation 15: Staffing

Staffing required review to ensure the skill-mix and number of staff was appropriate to meet the needs of the residents. For example;

- One activities co-ordinator was assisting and supervising 17 residents in Rose Cottage, which was in outbreak, for up to two hours.

- Residents reported they were often waiting for their call-bells to be answered, and inspectors also observed delays on the day of inspection. No additional staff had been considered for isolating and effectively managing an outbreak of COVID-19.

Judgment: Not compliant

Regulation 16: Training and staff development

- Training had been provided for staff during the outbreaks on hand hygiene. However, specific training on outbreak management had not been considered.
- Although training was completed in infection control practices, staff were observed not implementing the principles of training in practice, and there was ineffective supervision of staff practices as outlined further under Regulation 27: Infection control.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider did not ensure appropriate resources were in place to meet the needs of each resident at the time of inspection. One resident with a positive diagnosis of COVID-19 was not appropriately isolated and was found to be cared for in a dayroom alongside 16 other residents. One staff member was seen supervising this room.

The governance and management systems in place were not sufficiently robust to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored, in particular:

- Call-bell audits were carried out in respect of response times, but were not identifying delays in care and therefore they were not followed up with action plans
- There were no checks completed on functionality of the call-bells. On the day of inspection two call-bells were identified as not working by inspectors. This had been escalated to maintenance by staff and there was a delay in responding and a lack of clarity as to who was responsible for checking this. Inspectors were assured that the residents were provided with alternative temporary call-bells by the end of the inspection.

- Outbreak communication was weak. For example, staff were informed that mask-wearing was not mandatory in the areas of the centre that had an outbreak. This was not in line with best practice and posed a health and safety risk to residents and staff.
- Disparities between the finding of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the *National Standards for infection prevention and control in community services.* Examples of this are set out under Regulation 27: Infection prevention and control.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that residents generally reported a good quality of life in Craddock House Nursing Home where their rights were generally respected. However, some actions were required pertaining to premises, infection prevention control, as detailed under the relevant regulations.

Hand hygiene was supported by alcohol gel dispensers at the point of care for each resident. Clinical hand hygiene basins were available in clinical areas and in the dining areas that were open and accessible for staff. However, inspectors observed significant risks to the safety of the residents in respect of outbreak management and that IPC practices in place were poor as discussed further under Regulation 27: Infection Prevention Control.

Improvements had been made to the premises and it was generally well-maintained, with works being carried out in respect of upgrading the kitchen facility at the time of inspection. However, there were some areas that still required maintenance to ensure they were in line with the requirements of the regulation, as further detailed under Regulation 17: Premises.

Residents had good access to general practitioner (GP) services and there was evidence of regular medical review of residents when required. Residents had access to community mental health based services and health and social care professionals such as speech and language therapists and dietitians as required.

The registered provider had taken reasonable measures to protect residents from abuse, and training in abuse detection and prevention was provided to staff

Care plans were developed for residents and these were reviewed regularly and the quality of care plans had improved since the previous inspection.

There was a low incidence of pressure ulcers in the centre. There was appropriate timely access to professionals such as dietitian, speech and language therapists, physiotherapy and chiropodists.

Food appeared nutritious and in sufficient quantities. Residents had a choice of meals and were asked their preference on a daily basis. Residents were provided with snacks and refreshments throughout the day.

Regulation 11: Visits

Signage alerted visitors to the COVID-19 outbreak. Visits continued to be facilitated with infection prevention and control precautions in place. A small number of visitors were observed coming and going to the centre on the day of inspection.

Judgment: Compliant

Regulation 17: Premises

While generally the premises was kept in a good state of repair, some areas required improvement to ensure compliance with the requirements of Schedule 6. For example:

- The floor coverings in Room 30 and the sluice room in Rose Cottage required review as they were damaged and torn in areas and taped down to prevent the floor from lifting.
- Emergency call facilities were not accessible from each resident's bed. For example, the inspectors identified two call-bells which were not working on the day of the inspection.
- The inspectors asked for a full review of all the call-bells in the centre to ensure they were in good working order for residents to call for assistance.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

On the day of the inspection arrangements were in place for residents to receive their meals, which had been cooked and prepared in another designated centre as

an interim measure while the local kitchen facility was refurbished. Food was observed to be hot, wholesome and nutritious and snacks were available throughout the day.

Judgment: Compliant

Regulation 27: Infection control

The registered provider failed to ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff. The environment and equipment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- The detergent within one bedpan washer had expired several years ago. Staff were manually decanting the contents of urinals and commodes prior to decontaminating in the bedpan washer.
- Linen was not segregated in line with the centre's own policy for managing linen or the national policy of colour-coding for managing used linen and infected linen. For example, soiled linen was covered in a water soluble bag and placed alongside residents' clothing and other used linen and there was no designated bags for soiled linen.
- Urinals were used by residents when necessary. Some of the urinals found in the bathrooms were visibly unclean and not reprocessed in the bedpan washer.

The registered provider failed to 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. For example;

- One resident who was in their isolation period for COVID-19 was cared for in the Rose Cottage day room alongside 16 other residents. An immediate action was issued on the day and the resident was isolated in their bedroom as a result.
- The inspectors identified that effective transmission-based precautions had not been implemented. For example: clinical waste bins were not appropriately placed outside the rooms of residents who were isolating.Three staff members were observed not wearing the appropriate personal protective equipment (PPE) whilst caring for residents in the outbreak zone.
- One activity staff member had worked across two units on consecutive days, posing a risk to further spread the infection.

The registered provider had failed to ensure that staff receive suitable training on infection prevention and control.

- Training had been provided for staff during the outbreaks on hand hygiene. However, specific training on outbreak management had not been considered. This training was important given the fact it was the fourth outbreak in five months.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Improvements had been made in the oversight of medication management in the centre. All staff nurses had completed medication management training. There was a procedure in place outlining the management processes such as the ordering, prescribing, storing, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A sample of resident assessments and care plans were reviewed on this inspection. The care plans reviewed were person centred and outlined the residents' wishes and preferences.

Judgment: Compliant

Regulation 6: Health care

The inspectors found that residents had access to appropriate medical and allied health and social care professional support. Residents had access to a general practitioner who attended the centre on a weekly basis.

Judgment: Compliant

Regulation 8: Protection

The registered provider took reasonable measures to protect residents from the risk of abuse. There was a safeguarding policy in place that included the steps to take when there was suspected or confirmed abuse identified. The centre was not acting as a pension agent for any resident.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Craddock House Nursing Home OSV-0000027

Inspection ID: MON-0047241

Date of inspection: 10/06/2025

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

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The dependency levels of residents are reviewed monthly or sooner if a resident's needs change significantly by the PIC. This will help determine the required staffing levels for each house. Rosters are planned in line with residents' assessed levels of dependency and required skill mix to ensure safe and effective care delivery. Going forward staff rota will be adjusted based on the complexity and health conditions of residents (e.g., dementia, high fall risk, IPC outbreak, wound care needs). The rosters are reviewed daily to ensure safe staffing and appropriate skill mix to meet resident needs in each house including Rose Cottage. The center has also identified the importance of an appropriate skill mix on duty each day and this is overseen by the PIC. A comprehensive observational audit was completed over a 2-day period following the inspection. The purpose of this audit was to evaluate the current working practices including staff roles and responsibilities, break schedules, supervision of care delivery and to identify any gaps relating to skill mix and staffing in meeting the residents' needs and preferences. As a result of this review, several key actions were implemented: • Staggered Staff Breaks: Staff breaks are now taken on a staggered basis to ensure continuous coverage. This change ensures that staff are always available to respond to residents' needs, including answering call bells promptly and maintaining safe supervision within the living areas of each household. • Effective Use of Resources: The revised approach promotes the consistent and effective use of staffing resources throughout the day, ensuring resident safety and quality of care. • Meal Assistance: Only staff who have received the necessary and appropriate training are assigned to assist residents with meals, ensuring safe and dignified support during mealtimes. These actions aim to strengthen the delivery of care, enhance supervision, and ensure that staffing is aligned with the individual needs and preferences of the residents. A supernumerary Clinical Nurse Manager (CNM) or senior nurse is present across all houses seven days a week, ensuring that all aspects of resident care delivery are monitored and supervised effectively and that skill mix is appropriate when resident care	

is being delivered including mealtimes.
A supernumerary senior nurse is in place until the third Clinical nurse manager has been successfully recruited as discussed on day of inspection. There are currently 2.2 WTE Clinical Nurse in post with effect from 24th June 2025.

The above review is currently ongoing in the existing other 2 Houses in Craddock House

The management team has been assigned responsibility for a designated house within Craddock house . This includes attending daily handovers, supervising and monitoring of the delivery of daily care, overseeing infection prevention and control practices, reviewing incidents and falls,answering of call bells and ensuring a positive mealtime experience for residents in each of their respective houses.

An analysis of the call bell aduits including the call bell audit tool was completed for 2025 and following this review and analysis the following has been implemented since 05th July 2025;
• A revised call bell audit tool .
• Call bell audits are and will continue to be completed daily until 30 th September 2025 at different periods throughtout the day and night in all the exisiting houses .The frequency of call bell auidts will be reviewed on 30th September 2025.
• The answering of call bells is now an agenda item on the resident forum meeting
• Audit findings with the associated Quality Improvement plans are reviewed comprehensively by the senior management team during the weekly Governance meeting.These findings are also shared with the entire team ensuring all required actions and measures are implemented consistently.
• Ad Hoc Call bell response times and Spot checks are being completed throughout the week and are included in the Daily Quality Assurance Checklist completed by the management team on duty in each house.
During the recent Resident Forum Meetings on 8th and 09th July, a senior member of the management team delivered a demonstration to the residents on activating the call bell and outlined the procedure for residents to follow should they perceive response times are unsatisfactory at any time. Newly admitted residents will be provided with the same demonstration.
Information educational sessions reagrding the call bell policy occured with all staff so as to reiterate the importance of answering call bell . Expected response times were reinforced, supported by daily audit data. Call bell response times will continue to be a standing agenda item in all resident and staff House meetings moving forward.
Should there be any concerns or issues expressed by residents relating to delays in call bell responses are managed under the complaints procedure.
During the recent COVID-19 outbreak, additional care hours were promptly allocated to support residents in isolation and had ceased on 03rd June 2025 demonstrating a proactive response. However, it was identified that the need for enhanced supervision for one high-risk resident was not escalated in a timely manner.
Going forward, the following will be implemented in our Outbreak Management Policy and plan :
1. Implement an escalation protocol to ensure timely review and allocation of resources for isolated residents at high risk.
2. Strengthen Management Oversight at Daily Handovers:A management team member now attends daily handovers with effcet from 14th July 2025 in all three Houses to

monitor resident care, reinforce infection prevention and control practices, and ensure any need for additional supports is promptly identified and actioned.
3. Strengthen Communication and Escalation Protocols: Staff meetings held following the HIQA inspection (16th–18th June 2025) emphasised the requirement for staff to promptly escalate concerns regarding residents at risk of falls who require isolation. This will ensure the timely implementation of additional control measures, including adjustments to safe staffing levels.
4. In the event of future outbreaks, agenda items will include residents presenting with clinical risks such as falls, particularly if they are in isolation, as well as the measures or resources necessary to manage both the isolation process and the individual residents' clinical risks.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training has been completed by the Management Team on outbreak management and it is now included on the Training plan for 2025.

Induction training for newly appointed members of the management team has been reviewed and now includes Mandatory Outbreak Management Training.

Two Clinical Nurse Managers (CNMs) have been appointed as IPC Link Nurse Practitioners and have completed IPC Link Nurse training on 10th July 2025.
A review of existing IPC training being delivered to staff has been completed. Face-to-face IPC training including the infection prevention and control policywhich includes consistent with the standards published by the for all staff will be delivered by the IPC Link Nurses and completed by 30th September 2025.

As outlined under Regulation 15, a designated member of the management team is assigned to each house to ensure continuous monitoring and oversight of delivery of care including adherence to Infection prevention and control practices.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Our actions to achieve compliance with Regulation 23 align with the measures previously outlined (above) under Regulation 15. These actions, which are implemented or in progress, ensure strong governance through clear leadership presence, oversight of care delivery, and adherence to infection prevention and control practices. Further governance improvements will be incorporated into the Quality Improvement Plan to maintain sustained compliance.

1) The review and assignment of individual house responsibilities for managerial oversight will ensure that additional resources are allocated as required.
2) Daily Quality Assurance Checklist to be completed by the management team on duty in their assigned houses daily, including on-the-spot coaching and point-of-care mentoring on the supervision and coaching of staff.
3) Observational audits were completed on 11th and 12th July including a comprehensive review of staff practices, supervision of residents and allocation of staff break times. Changes were implemented to ensure sufficient staff presence at all times and to ensure residents receive appropriate supervision and assistance in the sitting rooms and during mealtimes.
4) The audit structure is currently under review with support from the Group Director of Quality, Safety and Risk, including additional audit training to be implemented regarding correct audit documentation and follow-up on learning and implementation practices by 31st July 2025.
5) Risk Management Training will be scheduled and completed by all managers and auditors by September 30th, 2025, to ensure audits are conducted thoroughly and resulting actions are implemented effectively.
6) The management team attends daily handovers in all 3 Houses to oversee residents' care, infection prevention and control practices, and to ensure that additional supports are identified and implemented where needed.

• A comprehensive review of the governance structure is in progress to ensure clear accountability, defined reporting pathways, and strengthened leadership presence across all houses. Management visibility is being enhanced through scheduled leadership rounds and unannounced stop-and-check inspections, which commenced in July 2025. A structured Learning and Development Programme, focusing on governance, regulatory compliance, leadership, and risk management, is currently being planned by the DQSR for rollout from Q3, with full implementation targeted by end of Q4 2025. Key priorities include embedding a strong focus on Health and Safety and Risk Management during Q3 and Q4, supported by enhanced training and proactive monitoring. Governance oversight is being strengthened through the planned implementation of a monthly governance dashboard on our KPIs and Audit outcomes, providing measurable and transparent performance indicators. The system will be live on or before end of August.
The call bells identified on the day of inspection were replaced by external contractors on Thursday 12th June.
A comprehensive assurance plan has been implemented to ensure call-bell functionality and responsiveness. All call bells were fully serviced by external contractors on 12th June

2025, and the Call Bell Policy has been updated to include clear roles, escalation procedures, and response timelines.
A Standard Operating Procedure (SOP) outlining immediate staff actions for non-functional call bells is in place and has been communicated to all teams through meetings and daily briefings. To strengthen governance, a twice-daily call-bell functionality checklist commenced on 12th June, verified by the Nurse in Charge, and all maintenance issues related to call-bells are classified as high risk within the maintenance log. The ongoing measures include daily monitoring, weekly governance reviews, quarterly trend analysis, and annual servicing by external contractors. These steps provide strong assurance that call bell safety is maintained, and risks are effectively controlled.

An outbreak plan, developed on 26th May following the confirmation of the outbreak, outlined clear control measures, including the safe use of face masks. However, it was subsequently identified that staff in one house received incorrect verbal instructions regarding appropriate mask usage during the outbreak. In response, clarity regarding the correct use of face masks was immediately communicated to all staff on the day of inspection. This message was reinforced through daily handovers, team meetings, and written communications, and continued until the outbreak was declared closed.
Following a comprehensive Infection Control Audit conducted by RPR over three days ending 10th July 2025 and review of existing Infection Control Program, the following actions are taken:
1) The comprehensive IPC audit tool has been reviewed, and moving forward, it will be completed by the Senior Management Team every quarter.
2) From August 2025, Senior Management will conduct weekly IPC assurance spot checks alongside daily CNM IPC checking. Learning outcomes and quality improvement plans will be documented and discussed on a weekly basis.
3) Weekly IPC compliance logs from department leads will commence in August 2025
4) 100% staff IPC training compliance will be achieved by 30th September 2025, ensuring that staff receive department-specific infection control training relevant to their roles.
5) Completion of enhanced IPC Link Nurse training in September 2025.
6) A comprehensive and updated outbreak management plan is in place, ensuring clear roles, communication and escalation pathways, risk management, and effective containment strategies.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The floor covering in Room 30 was replaced on 13th July 2025.
The floor covering in the sluice room in Rose Cottage was replaced on 18th July 2025

All call bell facilities were reviewed for accessibility and functionality on 12th June with no additional call bells identififed as not in good working order for residnets to access

and to call for assistance. The service of all call bells was completed by external contractors on 12th June 2025 and the two call bells identified as not working on the day of inspection were replaced on 12th June.
A Call Bell accessibility and functional checklist was implemented on 12th June 2025 and is completed twice daily at start of each shift. SOP is in place for staff to follow in the event that a call bell is not functioning including immediate escalation to management and to facilities and is communicated to all staff via team meetings.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The detergent was ordered following the inspection and has been in place since 17th June 2025. The detergent for bedpan washers is now incorporated into the revised Infection Control audit tool.

All staff completed refresher training on the appropriate disposal of contents from urinals and commodes by 11 June 2025, and this is recorded. Additionally, all staff also completed refresher training relating to the Bedpan Operating procedure.

The above practices and procedures were also reiterated during three separate staff meetings, completed on 18th July 2025, and staff compliance will be monitored.

Replacement linen trolleys were in place by 24th June 2025, laundry and linen is now segregated according to policy of colour coding.

A review of urinals was conducted, and any stained or damaged items disposed and immedialtely replaced. Daily IPC quality assurance checks include spot checks of equipment. The standard operating procedure for the cleaning and disinfection of urinals in the bed pan washer and disposal of stained and damaged urinals was reiterated during daily handovers and at House meetings on 16th, 17th, and 18th June 2025. This however will be ongoing, and a stock of new urinals are stored in the centre.

Clinical waste bins were appropriately placed outside the rooms of residents who were isolating by the end of the day of inspection.
The outbreak prepardeness plan has been updated to include the safe and appropriate use of clinical waste bins.
In the event of future outbreaks the centres outbreak management plan has been updated and includes the cross over of staff, and the overall management of staff.

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	18/07/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	18/07/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the	Substantially Compliant	Yellow	18/07/2025

	residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.			
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	30/08/2025
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	Orange	30/09/2025
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.	Not Compliant	Orange	25/07/2025
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate	Not Compliant	Orange	25/07/2025

	national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.			
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Substantially Compliant	Yellow	30/09/2025