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:	Croft Nursing Home
Name of provider:	Croft Nursing Home Limited
Address of centre:	2 Goldenbridge Walk, Inchicore, Dublin 8
Type of inspection:	Unannounced
Date of inspection:	19 September 2025
Centre ID:	OSV-0000028
Fieldwork ID:	MON-0048288

About the designated centre

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

The Croft Nursing Home is located just a few miles from Dublin city centre and within walking distance of Inchicore village. The home is a single-storey building providing accommodation for 36 long stay beds. Accommodation is configured to address the needs of all potential residents and includes superior single, companion and shared accommodation with assisted bath and shower rooms. There are a number of lounges and reading areas located throughout the building. The centre also has access to a secure garden area for residents to use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	34

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
Friday 19 September 2025	08:00hrs to 16:00hrs	Sharon Boyle	Lead
Friday 19 September 2025	08:00hrs to 16:00hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they were happy living in the centre and they spoke positively regarding the service and support they received. One resident told inspectors 'staff are lovely, I like to potter about but I like my room', another resident told the inspectors 'the food is exceptional and the staff would do anything for you'. However, the findings of this one day unannounced inspection was that action was required by the registered provider with regard to the premises, infection control and governance and management to ensure the service is safe and appropriate to the needs of the residents.

On arrival to the centre the inspectors were met by the person in charge. Following introductions and a brief explanation of the purpose of the inspection, the inspectors walked around the centre giving an opportunity to review the living environment and to meet with residents and staff. The inspectors observed that the centre was unclean at this time, floors were sticky and rubbish was seen on corridors and in the dining room. Cobwebs and spiders were observed on corridors and in communal bathrooms. One of the two toilets designated for use by 13 residents was found to be soiled and not fit for use. This was brought to the attention of the person in charge at 08:10. Despite this, residents continued to have access to this toilet and no action was taken until the inspectors requested the housekeeping staff to clean the area at 10:20. This will be further discussed later in the report.

Since the previous inspection, a number of multi-occupancy bedrooms had undergone refurbishment. The registered provider had committed to a completion date for the painting of architraves, skirting and walls for 30 October 2025, and there was a painter on site painting the corridor walls on the day of the inspection.

The centre is situated on the banks of the grand canal and is accessed by a lane along the canal to the front of the centre. The building is a period residence to the front with extensive addition to the rear where most of the accommodation bedrooms are located. All of the designated centre is at ground floor level, with exit routes available from each corridor to the outside. Given the nature of the building, the layout of the corridors and access routes, has resulted in some of the dining spaces being used as through ways. In order to move between the front and the rear sections, residents staff and visitors must progress through the main dining space. Many access routes had ramps to accommodate the change in level, and handrails were provided.

Most of the resident bedrooms are multi-occupancy rooms. Eleven are twin rooms, one is a triple room and the remaining eleven are single rooms. None of the multi-occupancy rooms have en-suite facilities, however, inspectors noted that each room was provided with a resident sink with many of these rooms being provided with a sink for each resident. While the inspectors noted that the space within the rooms was small, they had been reconfigured to allow the residents privacy and ensure that each residents space was defined within the room. Inspectors noted that many

of the rooms were not provided with lockable storage, however, management at the centre actioned this on the day of inspection to ensure residents had access to lockable storage as per regulations.

During the walkaround, inspectors noted that a resident was smoking in their bedroom. The smell of the smoke was noticeable along that bedroom corridor. As well as being unpleasant for residents staff and visitors, this smoking activity was imposing a fire safety risk to residents on this corridor and action was taken by the provider on the day to remove the risk. Inspectors could see that fire safety upgrade works had been completed including upgrades to fire doors, and building services such as the fire detection and alarm system. However, inspectors noted during the inspection, that many doors were fitted with devices to keep them open which deactivate on the sounding of the fire alarm. These devices were not always in serviceable order because they required batteries. This resulted in some doors being propped open, which were released by staff when brought to their attention. Fire safety is discussed further later in the report.

The atmosphere in the centre appeared relaxed with staff attending to residents care needs in an unrushed manner. It was evident that the residents were well known to the staff. The inspectors observed gentle and kind interactions between residents and staff. Residents were seen to mobilise around the centre freely and decided where and when they choose to have their meals. Some residents were observed having breakfast in the dining room while others decided to have breakfast in their bedrooms. One resident told the inspectors that 'staff are better than anywhere else'.

Residents were complimentary about the food in the centre, and they were provided with a good choice of food and refreshments throughout the day. During mealtimes, those residents who required help were provided with assistance in a sensitive and discreet manner.

There was a schedule of activities to suit all residents abilities and interests. A number of residents' said they enjoyed the bingo and particularly the music sessions which are organised. There was music scheduled for the afternoon of the inspection and the inspectors observed residents singing, tapping their feet and dancing with staff members.

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

Capacity and capability

This was an unannounced inspection conducted by inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in

Designated Centre for Older People) Regulation 2013 (as amended). Inspectors also reviewed the action taken by the registered provider to address issues of non-compliance with the regulations found on the previous inspection in June 2025.

As a result of previous non-compliance with Regulation 17: Premises regarding the layout of multi-occupancy rooms not supporting residents' rights to privacy and dignity, a condition to the registration of the designated centre was attached. The registered provider was required to reconfigure the multi-occupancy bedrooms by no later than 31 March 2024 as part of this condition. Following the inspection in June 2025 the provider submitted an application to remove condition 4 from their registration on the basis that they had completed the reconfiguration works by the end of August 2025.

The findings of this inspection, were that while the registered provider had taken some action to address concerns regarding care plans and the premises, there was further action required to ensure effective oversight and management systems were in place in order to achieve full compliance with regulations including infection control, premises, fire precautions and governance and management.

The registered provider of Croft Nursing Home is Croft Nursing Home Limited, which is part of the wider Silver Stream Health Care Group who operates a number of other designated centres nationally. The person in charge is supported in their role by an assistant director of nursing (ADON) and a clinical nurse manager (CNM). There is a senior management team in place to provide management support and a local team of staff nurses, health care assistants, administrative, catering and domestic personnel complete the complement of staff supporting residents in the centre.

Although staffing levels on the day of the inspection were sufficient, the absence of a staff nurse required the ADON to undertake direct nursing care duties. Inspectors were informed that this was not a once off occurrence and this had happened on other occasions previously. As a result, the ADON was unable to provide management support which had an impact on the governance and management of the centre as evidenced by the findings of this inspection.

The registered provider had detailed in the previous inspection compliance plan actions taken to enhance the governance and management oversight of the centre. These actions included dedicating supernumerary time to the management team in the centre to ensure consistent oversight of care delivery, employment of a CNM and ADON and developing a quality improvement plan to ensure oversight of audits. Inspectors found that while the ADON and the CNM had both commenced in their roles, the quality improvement plans were not developed and the oversight systems were not effective or robust and will be discussed further under the regulations.

Audits in relation to care plans, infection control and the environment were conducted regularly in the centre. Although these audits identified findings similar to those noted during this inspection, no quality improvement plans were implemented to specify corrective actions or assign a responsible person. Additionally oversight of staff practices in response to an environmental audit recently carried out was

ineffective. This will be discussed under Regulation 23: Governance and Management.

Inspectors also found that there were a number of statutory notifications relating to incidents that occurred within the designated centre which were not submitted to the Chief Inspector in line with Regulation 31: Notification of incidents.

The management of fire safety required further resources. In order to assess the overall risk of fire, the provider was relying on a fire safety risk assessment completed in 2022, however, this risk assessment concentrated only on the fire doors within the centre. The overall impact of fire risks on residents, the mitigation measures and the ongoing assessment of those risks was not carried out. The fire safety policy available to inspectors on the day of this inspection was out of date, and named a staff member that no longer worked at the centre as the appointed person for management of fire safety. Observations of a resident's smoking behaviour was not in line with the fire safety policy, nor was it in line with the individual smoking assessment for that resident. These are discussed further under regulation 23 Governance & Management.

Regulation 15: Staffing

Although staffing levels on the day of the inspection were sufficient to meet the assessed needs and dependencies of residents, the requirement of the ADON to undertake nursing duties adversely impacted on the skill mix within the centre. This resulted in deficits in the day to day management and oversight of the service as evidenced by

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management arrangements in the centre did not ensure that the service was operated in line with the requirements of the regulations.

Not all incidents notifiable to the Chief Inspector were notified in line with the regulations as set out under Regulation 31

The management and oversight systems in place were not sufficient to ensure that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by the following findings;

- Oversight of staff rosters did not ensure the skill mix was appropriate to ensure effective oversight systems in place

- While cleaning audits were conducted these were done on a monthly basis by an external company. There was no oversight of the hygiene standards within the centre on a daily basis, this impacted on the ability to identify immediate risks, and implement timely corrective action to ensure safe standards of hygiene.
- Actions committed to in the previous inspection compliance plan were not actioned for example; quality improvement plans were not developed or implemented following environmental and hygiene audits.
- The overall management of fire safety required significant improvement to identify fire safety risk and to address known fire safety risks such as smoking. During the inspection the provider committed to completing a fire safety risk assessment using a competent fire safety expert.
- The fire safety policy available at the centre was not updated, and was not implemented in order to reduce the risk of fire to residents.
- Notifications required by regulations were not submitted.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that incidents set out in paragraphs 7 (1) (a) to (i) of Schedule 4 of the regulations were notified in writing to the Chief Inspector. For example;

- One serious incident to a resident that required hospital admission was not notified through an NF03
- One allegation of a safeguarding concern was not notified through an NF06

Judgment: Not compliant

Quality and safety

Overall, the inspectors found that the residents were looked after by a caring staff team, and residents were very happy living in the centre and with the service they received. Residents received care and support from a team of staff who knew their individual needs and preferences. Resident's had good access to a team of allied care professionals and care was provided in line with their assessed needs. However, the findings in relation to premises, infection control and fire precautions did not align with the requirements of the regulations.

The centre was found to be well-lit and warm. A programme of maintenance work was underway to address areas of the centre which were in a poor state of repair.

These works were scheduled to be complete by the end of October 2025. The registered provider had completed the reconfiguration and upgrading of the multi-occupancy rooms and these were seen to be freshly painted.

On reviewing the premises available to residents, inspectors found that some spaces for the use of the residents including a conservatory area, was used for storage of furniture items and other building materials from the premises upgrade.The upgrades to the centre were being completed on the inspection day with painters working on hallways. On reviewing the reconfigurations which had been completed to the multi-occupancy rooms, the provider had identified that in many cases, only one of the residents within the room could be facilitated for hoisting during care needs, or for mattress evacuation. This was due to insufficient space to complete these actions for both residents without impacting on the other residents space. The rooms were configured to allow this level of dependency to be accommodated in one of the beds, however, the specific bed was not identified. These issues are outlined under regulation 17 Premises.

Inspectors reviewed arrangements in place at the centre to protect residents from the risk of fire. There were serviced fire safety equipment, such as a fire detection and alarm systems, emergency lighting and fire extinguishers. All rooms had escape routes that allowed evacuees to turn away from the source of a fire, and evacuate in the opposite direction to an exit door at ground level. Escape routes were noted as being narrow due to the nature of the building but were kept clear. There were fire doors installed on corridors and to resident bedrooms. However, significant fire containment concerns were noted along some of the escape routes, including at the main entrance reception area. Measures to restrict the spread of fire smoke and fumes in the event of a fire, can provide valuable time to evacuate residents. This would be critical to the implementation of the providers stated method of evacuation which was progressive horizontal evacuation. This evacuation method requires staff to move residents from the compartment area affected in the event of a fire, to an adjoining compartment of relative safety before moving further. Fire evacuation drills completed, did not indicate that staff could move all residents within the largest compartment to an adjoining compartment in a reasonable time. Management committed to ensuring further training was implemented immediately after the inspection. These issues are discussed further under Regulation 28: Fire Precautions.

While there was adequate space for residents to store their personal belongings, not all residents had access to lockable storage for safe keeping of personal valuables as set out in Schedule 6(3)(h) of the regulations. However, inspectors saw evidence that management had purchased appropriate lockable storage for these residents on the day of the inspection.

Residents had access to television, radio and newspapers and were supported to receive visitors in private or in communal areas as per their wishes. Residents meetings were held on a regular basis. From a review of the recent meeting minutes held in August 2025, inspectors found that residents had good opportunity to participate in the running of the designated centre and were kept updated about key matters relating to the service they received including food and the menu, upgrades

to the centre, new staff and social events. There was an activity schedule in place, and residents were provided with activities in accordance with the activity on display, and their interests.

Improvements were seen in a sample of residents' individual assessment and care plans which were reviewed by the inspectors. There was evidence that residents needs had been assessed using validated assessment tools, and all residents had a care plan, the care plans were reflective of residents' assessed needs and updated following a change in their needs.

The inspectors observed the meal time experience for residents. There was sufficient staff available to assist residents with their meals in the dining room, communal room or bedroom, whichever the resident choose at the time. Some residents required staff to assist them with their meals. Where this was the case, staff were seated next to the residents, providing discreet and gentle support to residents.

Regulation 12: Personal possessions

Residents had access to, and retained control over their own personal property and possessions. Clothing were laundered regularly and returned to the resident. Residents also had adequate space to store and maintain their own clothes and personal possessions.

Judgment: Compliant

Regulation 17: Premises

Ongoing premises upgrades were taking place at the time of this inspection, including works identified in the previous inspection which were within the providers time frame for completion.

Improvements were required of the registered provider to ensure that the premises is in line with the Statement of Purpose and the floor plans for which it is registered. For example:

- In some multi-occupancy rooms, one of the beds was required to be maintained for low dependency residents, however, this bed space was not clearly identified at the bed or in the statement of purpose.
- The conservatory was being used as a storage space for furniture. Some of this furntiure was moved to the conservatory during renovation works, however, some of the furniture cabinets were placed there permenntly. All of

the communal space intended for the use of residents was not available to them.

Improvement was required of the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- There was no lockable storage available to some residents near their bed space. This was rectified by the provider shortly after the inspection.
- A rainwater gutter was damaged outside one bedroom. It was raining on the day of inspection, and a significant amount of water was flowing from this gutter causing noise within the bedroom.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents had access to fresh water and snacks throughout the day. There was a choice at mealtimes for residents and an adequate number of staff to assist at mealtimes. Food was observed to be wholesome and nutritious and freshly prepared on site.

Judgment: Compliant

Regulation 27: Infection control

Further improvement was required to ensure that infection prevention and control procedures were consistent with the standards published by the authority and appropriate national authorities and were implemented by staff. This was evidenced by;

- Recommendations from a recent environmental audit were not implemented by staff. For example; signage at the entrance to the kitchen required all staff to wear a hair net and apron, inspectors observed a number of staff, including catering staff, fail to comply with this request which poses a risk to the contamination of food from hair and clothes.
- Inspectors observed spiders, cigarette butts, rubbish and dirt in the shower rooms, bathrooms and corridors throughout the centre which demonstrated poor hygiene standards and ineffective cleaning systems and oversight.
- While there was a cleaning schedule in place management did not review or update it to ensure cleaning was prioritised according to need, to minimise health and safety risks to residents. For example; one toilet was observed to be soiled and remained in use for residents, this posed a significant risk to

infection prevention and control and increased the likelihood of cross contamination among residents.

This is a repeat finding.

Judgment: Not compliant

Regulation 28: Fire precautions

Some areas of fire safety required significant improvements to align with the requirements of the regulations and to provide residents with appropriate protection from the risk of fire.

Improvement was required by the registered provider to take adequate precautions against the risk of fire and to provide suitable fire fighting equipment. For example:

- Storage practice was presenting a risk of fire, as flammable and combustible materials were stored in close proximity to each other in the conservatory and in the maintenance shed.
- Smoking protocols were not being followed by staff resulting in a fire risk in the residents area where a resident was smoking. Appropriate controls were not being implemented, which substantially increased the risk of fire in this area. The provider implemented a revised smoking procedure following this inspection, which eliminated this risk.

Improvement was required from the registered provider to ensure, by means of fire safety management and fire drills at suitable intervals, that persons working in the centre and, in so far as is reasonably practicable, residents are aware of the procedure to be followed in the case of a fire. For example:

- While regular fire drills were being completed at the centre, there was no drill reflecting the largest compartment including the dependency level of the residents in that compartment. This meant that the provider could not be assured that all residents in the higher risk large compartment areas could be evacuated in a reasonable time in the event of a fire, including at times of low staff numbers such as night time.

The registered provider did not make adequate arrangements for containing fires. For example:

- The reception area was an exit route which opened onto a bedroom corridor. The exit route was not protected on either side of the reception desk as the nurses station and the director of nursing office were not adequately separated with fire rated construction from the escape route. As a result there was increased fire risk in both rooms which would impact on the escape route.

- Appropriate fire containment in a number of areas including a service cupboard housing a hot water tank, the attic space, a storage area on the escape route did not appear to be in place. This could result in a faster fire spread, and put the escape routes at risk in the event of a fire and horizontal evacuation.
- Fire stopping materials were not in place along the compartment wall between the boiler room and an evacuation corridor. The boiler room is a high fire risk room, as well as having the potential to spread fumes and smoke to the resident bedroom corridor.
- From a sample of doors viewed further review of these doors was required to ensure that devices that release the door from an open position were operating effectively, that smoke seals were fully intact, that the doors have the appropriate fire rating, and that they are fitted with appropriate ironmongery (hinges & handles).

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The centre had an electronic resident care record system. A range of validated nursing tools were in use to identify residents' care needs. The inspector viewed a sample of files of residents with a range of needs and found that care plans viewed were detailed, informative and reviewed in line with regulatory requirements.

Judgment: Compliant

Regulation 6: Health care

Residents' health care needs were met through regular assessment and review by their general practitioner (GP). Residents were also referred to health and social care professionals such as dietitians, tissue viability nurse specialists, and speech and language therapy, as needed. A physiotherapist attended the centre weekly and referrals were made to occupational therapy services as required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to facilities for occupation and recreation and opportunities to participate in activities in accordance with their interests and capacities.Residents

were consulted about and participate in the organisation of the centre through residents meetings and surveys and residents were able to exercise choice in how they spend their time living in the centre.
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 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Croft Nursing Home OSV-0000028

Inspection ID: MON-0048288

Date of inspection: 19/09/2025

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required: • A comprehensive procedure and protocol are in place to guide the management of staff absenteeism in the Home. The Person in Charge has been reminded of this process to ensure consistent application and full compliance going forward. • The Roster is managed by PIC and reviewed by the member of RPR Team to ensure safe staffing levels and skill mix are maintained at all times including adequate supervision and oversight of the services in the centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure compliance the Registered Provider will have the following implemented and actioned as required: • To ensure all incidents notifiable to the Chief Inspector are reported within the prescribed timeframe, a member of the RPR Clinical Governance Team reviews all incidents recorded on the centre's incident log. The Person in Charge (PIC) is notified immediately of any incidents requiring submission to the Chief Inspector to ensure timely and accurate reporting. • The Roster is reviewed regularly to ensure that it will meet the identified needs of the residents. The process for managing absenteeism has been reviewed with the PIC. • Additional cleaning audits have been introduced and discussed on the day of findings with a senior member of the external cleaning company to ensure actions are taken and compliance is maintained and learnings discussed and disseminated to staff. Where	

required, a Quality Improvement Plan is initiated and followed up within two weeks to confirm completion and compliance.
• The Registered Provider has engaged a Fire Safety Consultant to complete a FRA of the entire premises, and the impact that fire safety would have on each resident and a time bound action plan to address recommendations arising from this assessment will follow upon completion and findings will be actioned.
• The Fire policy has been updated and all staff made aware of this update.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure compliance the Registered Provider will have the following implemented and actioned as required:
• To ensure all incidents notifiable to the Chief Inspector are reported within the prescribed timeframe, a member of the RPR Clinical Governance Team reviews all incidents recorded on the centre's incident log. The Person in Charge (PIC) is notified immediately of any incidents requiring submission to the Chief Inspector to ensure timely and accurate reporting.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure compliance the Registered Provider will have the following implemented and actioned as required:
• The Statement of Purpose has been updated to clearly identify the beds designated for low-occupancy use. Prior to each new admission, a member of the RPR Clinical Governance Team reviews with the Person in Charge to confirm the suitability of the resident for the identified bed space.
• A review of the conservatory area has been completed, and several cabinets have been removed to ensure that this communal space is fully available and accessible for resident use.
• Each resident now has access to lockable storage located near their bed space, ensuring privacy and security of personal belongings.
• The guttering system has been repaired.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
To ensure compliance the Registered Provider will have the following implemented and actioned as required:

• All catering staff have been reminded of the requirement to wear hair nets and aprons at all times while in the kitchen. In addition, all staff entering the kitchen area have been reminded of this requirement, and adequate supplies of hair nets and aprons are readily available at the kitchen entrance.
• A full deep clean of the premises was completed by the external cleaning company following the inspection, and all issues identified on the day have been addressed. To prevent recurrence, regular meetings are held with the cleaning company to review standards, address any findings immediately, and ensure compliance.
• Cleaning staff have been met with and reminded of their responsibility to address any hygiene or cleanliness issues identified by residents or other staff members promptly and to escalate any unresolved matters to the Person in Charge without delay.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: To ensure compliance the Registered Provider will have the following implemented and actioned as required:
• A comprehensive review of storage has been completed and dedicated areas for storage have been put in place and will be reviewed at each visit by a member of the RPR Governance team to ensure ongoing compliance.
• The smoking protocols and individual risk assessments for residents who smoke have been reviewed and updated. The PIC and their team will monitor compliance with these protocols on a daily basis, and a member of the RPR Governance Team will review adherence during site visits to ensure continuous oversight.
• A Fire drill SOP has been implemented to ensure that all staff participate in drills covering the centre's largest compartments. The PIC has conducted daily drills to familiarise all staff with evacuation procedures, and fire drills will continue to take place monthly. Each drill will be reviewed by a member of the RPR Governance Team to ensure that learnings are recorded and acted upon promptly.
• The reception area and adjoining Nurse Station will have suitable compartmentation put in place to ensure the exit route is protected as required. This work will be carried out by a competent firestopping contractor and certified accordingly.
• Fire containment in the service cupboard and storage area are currently having remedial works carried out by a firestopping contractor. All attics will be inspected to ensure fire compartmentation is being maintained above ceiling levels as required. Extensive work had been carried out in 2022 in that regard but will be checked and verified as correct.
• Fire stopping materials in compartment wall between boiler room and evacuation corridor will be inspected and any corrective works required such as service penetrations will be addressed by a firestopping contractor.
• Fire doors will be inspected by a competent person to ensure the closures are working, fire seals fully intact, fire rating and appropriate ironmongery are in place and will be inspected / audited as required and any remedial works will be actioned accordingly.

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.	Substantially Compliant	Orange	12/11/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared	Substantially Compliant	Yellow	12/11/2025

	under Regulation 3.			
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	12/11/2025
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	12/11/2025
Regulation 23(2)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	12/11/2025
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	Substantially Compliant	Orange	12/11/2025

	implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/03/2026
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/03/2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of	Not Compliant	Yellow	12/11/2025

	the incident within 2 working days of its occurrence.			