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:	St Martha's Nursing Home
Name of provider:	Elder Nursing Homes (Charleville) Limited
Address of centre:	Love Lane, Clybee, Charleville, Cork
Type of inspection:	Unannounced
Date of inspection:	05 December 2025
Centre ID:	OSV-0000291
Fieldwork ID:	MON-0048319

About the designated centre

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

St. Martha's Nursing Home is a purpose built, single storey premises set back from the main road on the outskirts of Charleville, Co. Cork. The centre provides accommodation for up to 36 residents in twenty two single and seven twin bedrooms. Thirteen of the single bedrooms and two of the twin bedrooms are en suite with shower, toilet and wash hand basin. The remaining bedrooms are equipped with a wash hand-basin facility. The centre accommodates both female and male residents for long-term care and also facilitates short-term care for residents requiring convalescence, respite and palliative care. The centre caters for residents assessed as low, medium, high and maximum dependency. There is an internal courtyard which is accessible to residents that wish to spend some time in the open air.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	31

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 5 December 2025	10:00hrs to 17:30hrs	Siobhan Bourke	Lead

What residents told us and what inspectors observed

During this unannounced inspection of St. Martha's Nursing Home, residents and visitors, who met the inspector, gave positive feedback regarding the kindness and care they received from staff working in the centre.

The inspector walked around the centre on arrival and met with many of the staff and residents during this time. The inspector saw that staff were providing morning care to residents and were observed knocking, prior to entering residents bedroom,s to provide personal care and were heard greeting residents in a friendly manner. Some of the residents were already up and sitting in the day room, ready for the day's activities. Many residents were living with a cognitive impairment in the centre and could not fully express their opinions to the inspector, however they appeared content in their environment.

St. Martha's Nursing Home is a single storey building, located near Charleville town and is registered to accommodate 36 residents. Accommodation in the centre is in two units, side A and side B, with seven twin rooms and 22 single rooms. Thirteen of the single rooms and two of the twin rooms had en suite shower and toilet facilities, while the remaining rooms had wash hand basin facilities only. The centre also had an assisted bathroom and toilet and two assisted shower rooms with toilet facilities. Many residents' bedrooms were personalised by residents and the inspectors saw that they were clean. Residents also told the inspector that the staff kept their bedrooms clean. Residents confirmed that when they called for assistance staff attended in a timely manner and the inspector saw that new call bell leads were in residents' bedrooms. Bedroom furniture such as lockers and wardrobes had been replaced or repaired in many of the bedrooms and it was evident that rooms and corridors throughout the centre had been painted. Drop seals on bedroom doors had been applied to increase the fire containment in residents' bedrooms and the inspector saw that door holding devices had been replaced since the previous inspection. Many of the bedroom door locks had been replaced, however one bedroom door on Side A, had a gap arising from the keyhole that required review. This is outlined further in the report.

Residents had access to two day rooms that were separated by an archway; as well as a dining room and a bright sun room. Communal rooms were nicely decorated and had televisions, home style dressers and lamps that gave the rooms a homely feel. Both the day rooms and the sun room had new flooring that greatly improved the décor in these rooms. New armchairs and dining room furniture had also been purchased. A small area of flooring in one of the corridors was torn and required repair or replacement.

The inspector observed the dining experience at lunch time and the evening meal and saw that the majority of residents choose to eat in the dining room and were served together at tables that were nicely decorated. Residents were complimentary

regarding the meals and snacks offered to them. Residents who required assistance were provided with this in a respectful and unhurried manner. Each table had a menu displayed. The menu displayed indicated that the choice for the lunch time meal was battered cod and chips or savoury mince as the choices available. The inspector saw that steamed cod and mash or roast potatoes were served rather than what was on the menu displayed. This is outlined further under Regulation 9; Residents' rights.

During the course of the inspection, the inspector observed many person-centred interactions between staff and residents and many of the residents who spoke with the inspector confirmed that staff knew their preferences and were kind to them. It was brought to the attention of the inspector that on some night shifts, two male carers were rostered; a resident who spoke with the inspector outlined how their preference was for female care staff and therefore this impacted resident choice to their preferred gender of carer. This is outlined further in this report.

An activity co-ordinator worked full time in the centre and was supported with facilitating activities for residents by the care team. On the morning of the inspection, residents were reading the newspapers and having one-to-one chats with staff, while in the afternoon, a musician attended the centre and a lively music and song session was enjoyed by many of the residents. The inspector saw some of the residents dancing during this session with their relatives and staff while other residents sang along with the musician, which they appeared to enjoy. The schedule of activities included bingo, quizzes, crossword puzzles, music, exercises and mass was celebrated in the centre by a local priest once a week. Residents had access to independent advocacy services as required.

Residents meetings were held each quarter in the centre and from a review of minutes of these meetings, residents gave positive feedback on the activities, meal times and quality of meals provided.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection, carried out over one day by an inspector of social services. The purpose of the inspection was 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 inform decision making with regard to an application by provider to remove a restrictive condition on the centre's registration. The inspector found that overall additional resources had been put in place by the provider with regard to the premises, however the inspector found that some of the management systems in place were not effective to ensure the service

provided to residents was safe, appropriate, consistent and effectively monitored. Significant action was required to comply with the regulations pertaining to care planning, fire precautions, complaints management and notifications as detailed under the relevant regulations.

Elder Nursing Homes Limited (Charleville) is the registered provider for St. Martha's Nursing Home. The registered provider had designated operational management of the centre to Mowlam Health care Services Unlimited Company, who was notified to the office of the Chief Inspector as a change of person participating in management for the centre from Complete Health care Services Ltd in January 2025. There was a clearly defined management structure in place at an operational level, with clear lines of authority and accountability. The office of the Chief Inspector had been appropriately notified of the change of one of the persons participating in management for the centre, with the appointment of a new health care services manager in October 2025.

There had been a change of person in charge since the previous inspection and a new person in charge commenced in their role in October 2025. This person had the required experience and qualifications for the role as required in the regulations and was supported in their role by the health care manager and director of care services.

The person in charge for the centre was full time in position and was supported in their role by a clinical nurse manager and reported to a health care manager and director of care services within the Mowlam Healthcare Services management structures. Mowlam Healthcare Services Unlimited Company, as person participating in management for the centre had also recently appointed a quality and compliance manager who supported the on site team with training and audit functions of their role.

There was an adequate number and skill mix of staff available on the day of inspection to to ensure effective delivery of care and support to residents. The team providing care to residents comprised a clinical nurse manager, a team of nurses and health care staff. There were sufficient numbers of housekeeping, activities, catering and maintenance staff in the centre.

Staff were supported to attend both face-to-face and online training appropriate to their role. Staff had completed training such as fire safety, safeguarding of vulnerable people and manual handling techniques.

There were systems in place to monitor the quality and safety of care provided to residents. There was good oversight of key risks to residents such as monitoring of residents' weights, incidents of falls, use of restrictive practices, monitoring of wound and pressure ulcers and any medication errors. There were regular meetings between staff and management to ensure that communication of residents' care needs were effective. There was a system of electronic audit and data collection in place and the incoming person in charge was completing training on this system at the time of inspection. However, further action was required to ensure oversight of complaints management, incident notification and care planning as detailed under Regulation 23; Governance and management.

A complaints log was maintained on an electronic system in the centre. The procedure was displayed and the person in charge was the nominated complaints officer for the provider. From a review of a log of complaints maintained, while some complaints had been recorded and actioned, a number of complaints were not. These and other findings are detailed under Regulation 34; Complaints procedure.

The records of incidents maintained in the centre was reviewed. It was evident that where injury to a resident was suspected, appropriate first aid was administered and medical review sought when appropriate. However not all incidents were reported to the office of the Chief Inspector as required in the regulations. These are detailed under Regulation 31; Notification of incidents.

The provider submitted an application to the office of the Chief Inspector to remove the restrictive condition from the designated centre's certificate of Registration. Appropriate application form and required information were submitted as required.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The registered provider applied to remove a restrictive condition from the registration of the centre that required by the 31st of May 2025, the registered provider shall take all necessary action to ensure that the premises of the designated centre is appropriate to the number and needs of residents and that they are kept in a good state of repair externally and internally. The provider submitted the required form, fee and additional information to support this application.

Judgment: Compliant

Regulation 14: Persons in charge

A new person in charge had commenced in a full time position in the centre in October 2025. This person had the required nursing and management experience and qualifications to meet the requirements of the regulation.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, there was sufficient staff on duty with appropriate skill mix to meet the needs of all residents, taking into account the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix was reviewed and indicated that staff had undertaken mandatory training in areas such as safeguarding vulnerable persons from abuse, manual handling, fire safety and care of residents who experience responsive behaviour. It was evident to the inspector that staff were appropriately supervised on the day of inspection, by the person in charge and clinical nurse manager.

Judgment: Compliant

Regulation 23: Governance and management

The provider did not ensure that some of the management systems in place were effective to ensure that the service provided was safe, appropriate, consistent and effectively monitored, as required under Regulation 23(c), as evidenced by the following;

- The provider failed to ensure that complaints were managed in line with the regulations and the centre's own procedures
- There was a lack of oversight of legally mandated notifications: these were not submitted as required to the Chief inspector
- Oversight of care planning was not effective to ensure that care plans were detailed and accurate to direct residents' care needs.
- Oversight of fire precautions required action as evidenced under Regulation 28; Fire precautions.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of the incident log maintained in the centre and from speaking with residents, the inspector found that not all incidents were reported to the Chief Inspector as required under the regulations. A notification was not submitted following a loss of electrical power in the centre and a notification was not received when a resident had an unexplained absence from the centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure that all complaints were logged and managed as required in the regulations. From speaking with residents, not all complaints were recorded as required, furthermore a number of complaints were not investigated and responded to as evidenced by the following.

- There were no records maintained of two complaints raised by a resident with regard to the management of their medications and their preferred gender of care giver.
- There were no records maintained to indicate that the outcome of an investigation of a written complaint had been communicated to the complainant.
- A written response to a complainant reviewed, did not include details of the review process as required in the regulations.

Judgment: Not compliant

Quality and safety

The inspector found that residents were supported to have a good quality of life from kind and caring staff. However, action was required with regard to fire precautions, care planning, premises and infection prevention and control, to ensure the safety of the care and service provided to residents.

Residents had timely access to medical assessments and treatment by their General Practitioners (GP) and a GP was present in the centre,reviewing residents, on the day of this inspection. Where required residents were assessed by a physiotherapist and other health care professionals such as dietitians and speech and language therapists. Each resident had a care plan developed within 48 hours of admission and validated tools were used to inform care planning. Assessments were updated every four months, however, from a review of a sample of care plans, it was evident that some assessments did not reflect a resident's current condition nor were accurately recorded. These and other findings are outlined under Regulation 5; Individual assessment and care plan.

Residents gave positive feedback to the inspector regarding the quality and variety of meals and snacks provided to them. The inspector saw that residents could choose whether to eat their meals in the dining room or in their bedrooms. Residents were provided with assistance as required and residents eating in the day room were appeared to have a social dining experience.

Residents told the inspector they felt safe living in the centre and that staff were kind and respectful to them. Staff who spoke with the inspector were knowledgeable regarding when to report safeguarding concerns and had received training in this regard.

There was one housekeeping staff member rostered every day and two housekeeping staff members, three days a week, to ensure residents bedrooms were cleaned every day and deep cleaned regularly. Staff were knowledgeable regarding cleaning practices. The bedpan washer was found to be in working order and appropriate storage was seen in the centre's sluice room. The inspector saw that oversight of cleaning of patient equipment required action as outlined under Regulation 27; Infection control.

Inspections of the centre since 2022, found that the provider had failed to ensure that the premises were kept in a good state of repair to ensure a safe environment for residents. Following an inspection of the centre in June 2024, a restrictive condition was attached to the registration of the centre in August 2024, which required the provider to address repeated non-compliance found with the overall state of repair of the premises. The inspector saw that significant action had been taken by the provider with regard to the furnishes and finishes of the centre since the previous inspection. Flooring in the day rooms and sun room had been replaced. Furniture such as lockers and wardrobes in some residents' bedrooms had been replaced. New chairs and dining room furniture had been purchased and the inspector saw that many residents' bedrooms and communal areas had been painted to enhance the homely environment for residents. Some further action with regard to premises was required as outlined under Regulation 17; Premises.

The inspector examined the fire safety folder and saw that the staff working in the centre completed annual fire safety training as required. Regular evacuations of the largest compartment considering night time staffing levels was also under taken. Fire certification was available indicating that quarterly and annual servicing of the fire alarm and the emergency lighting was undertaken. The provider had completed a fire safety risk assessment since the previous inspection and immediate risks identified from this assessment such as the requirement to replace bedroom door hold open devices with an upgraded type connected to the fire alarm system, the provision of drop seals to the bottom of fire doors to contain the spread of smoke, upgrade to the fire detection and alarm system and provide training to staff on emergency response had been completed. However, a number of actions identified in the previous inspection of the centre and the fire safety risk assessment remained outstanding as detailed under Regulation 28; Fire precautions.

Residents confirmed with the inspector that they could get up and go to bed at a time of their choosing and they had choice in how they spent their day. A number of call bell leads had been replaced since the previous inspection and residents told the inspectors that their call bells were answered in a timely manner. A full time activity staff member was employed in the centre and was supported by external activity providers such as musicians. Residents' meetings were held regularly to seek residents' views on the running of the centre and the centre had appointed a resident representative who could raise issues on behalf of other residents. The

inspector found that improvement was required to ensure residents' choice of gender or carer was respected at all times as detailed under Regulation 9; Residents rights.

Regulation 11: Visits

Visits were unrestricted in the centre and residents and visitors confirmed that visitors were welcomed in the centre. Residents could meet their visitors in their bedrooms or in the communal spaces in the centre.

Judgment: Compliant

Regulation 17: Premises

It was evident to the inspector that good progress had been made to improve the upkeep of the premises since the previous inspection, however the following required action to ensure compliance with Schedule 6.

- A small area of flooring in one of the corridors was torn and covered with tape, which was a trip hazard risk.
- Some wear and tear to the paintwork in some resident bedroom walls which impacted the homeliness of these rooms.
- There was leak arising from a hole in the ceiling on one of the corridors that was being repaired on the day of inspection. The person in charge confirmed that this leak had been repaired in the days following the inspection.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector saw that residents were offered adequate quantities of meals and drinks that there wholesome and nutritious. Meals and snacks were observed to be served at appropriate times during the day. Residents gave good feedback regarding the temperature and quality of food they were served. Staff ensured that residents who required assistance with eating and drinking were provided with it in a timely manner.

Judgment: Compliant

Regulation 27: Infection control

The inspector found improvements in compliance with infection control practices since the previous inspection, however, oversight of the standard of cleaning of environmental and equipment required action;

- a number of raised toilet seats were noted to be unclean
- a bedroom that that been cleaned following the discharge of a resident had used slings stored in the bedroom
- staining was noted around a toilet and a leg rest was unclean in another resident's bedroom.

Judgment: Substantially compliant

Regulation 28: Fire precautions

As found on the previous inspection on the centre in February 2025; and from the fire safety risk assessment undertaken by the provider following that inspection, the following required action to ensure adequate precautions against the risk of fire and for reviewing fire precautions:

The arrangements for providing adequate means of escape including emergency lighting were not effective:

- the alternative escape from the large day room and Rose Day room was through one of two doors into the conservatory and subsequently the final exit from the conservatory. These doors would not be of adequate width for larger mobility equipment or chairs
- the provision of emergency lighting along external escape routes was not adequate to safely guide occupants from the exits to a place of safety.
- the provision of exit signage was not adequate; a number of compartment doors had escape signage to one side of the door only and in some corridors, there was a lack of visible escape signage to direct occupants towards the next compartment or exits
- external escape routes were not adequate; an exit to the rear led to a path and from there required egress across an uneven gravel surface which would not be conducive for mobility aids or evacuation aids

Fire doors were not being maintained in good working order, while drop seals had been installed in a number of bedroom doors, there was a hole in a bedroom door where a lock was removed.

Fire containment measures were not adequate; the integrity of fire compartment boundaries was not confirmed, penetrations and attic hatches were not sealed and the sluice room was not adequately enclosed in fire rated construction.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

From a review of a sample of care plans it was evident that action was required to ensure compliance with the regulations as evidenced by the following.

- While validated assessment tools were used to assess residents at risk of malnutrition, these were not always calculated correctly. For example one resident's malnutrition risk assessment indicated that their risk was zero even though they had experienced recent significant weight loss, which was not reflected in the assessment.
- A resident who had previously experienced responsive behaviour did not have their care plan updated to reflect their current condition.
- A second resident who experienced responsive behaviour did not have assessments completed as recommended in their care plan.

These findings may result in errors in care and treatment.

Judgment: Not compliant

Regulation 6: Health care

A GP was onsite reviewing residents on the day of inspection and from a review of residents' records, it was evident that residents had access to medical assessments as required. Systems were in place for residents to access the expertise of health and social care professionals through a system of referral, including speech and language therapists, dietitian services and tissue viability specialists. Community services such as palliative care team and mental health specialists also attended the centre when required.

Judgment: Compliant

Regulation 8: Protection

The inspector found that staff working in the centre, were knowledgeable regarding safeguarding vulnerable persons and had received suitable training in this regard.

Allegations or incidents of abuse were notified and investigated as required by the person in charge. Residents who spoke with inspectors reported that they felt safe living in the centre. The provider was a pension agent for four residents living in the centre and there was evidence that there was robust management of residents' finances.

Judgment: Compliant

Regulation 9: Residents' rights

Action was required to ensure residents' rights to exercise choice was upheld at all times as evidenced by the following;

- residents' choice with regard to the gender of carer providing personal care was not consistently upheld as two male carers were rostered on some nights which impacted this choice for residents.
- the inspector saw that the menu displayed on dining room tables did not reflect the choice that was offered to residents on the day of inspection, for example, battered cod and chips was on the menu displayed, while residents were offered steamed cod and mash or roast potatoes.
- A privacy curtain in one of the twin bedrooms was hanging down and did not ensure residents' privacy.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Martha's Nursing Home OSV-0000291

Inspection ID: MON-0048319

Date of inspection: 05/12/2025

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • There is a monthly management team meeting in the home which reviews all operational aspects of the home, including key performance indicators, risk management, incidents, and complaints. • The Person in Charge (PIC) and Healthcare Manager (HCM) will review complaints as part of their weekly review of all Key Performance Indicators (KPIs), and will ensure that complaints are reported, recorded, investigated and responded to in accordance with the centre's Complaints Procedure. Quality improvement plans will be developed and implemented to address any learning outcomes identified and the learning outcomes will be discussed with the wider team at the monthly management team meetings. • The PIC will oversee the assessment and care planning records and will ensure that care plans are audited in line with the Mowlam Audit timeline or more frequently should the need arise, such as when there is a change in a resident's condition. The Provider Representative will liaise with the Facilities Manager to ensure that the programme of works associated with fire safety is completed in accordance within appropriate timelines.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The PIC will ensure that all incidents and complaints are screened regularly and that all incidents that meet the criteria for notification to the Authority are submitted to the Chief	

Inspector within the required timeframe, in accordance with legislative requirements.
• The HCM will monitor compliance with this regulation as part of weekly management meetings with the PIC.
• The PIC and HCM will continue to review incidents and complaints weekly and will ensure that quality improvement plans are reviewed and updated as necessary.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC will ensure that all staff, including the management team, complete complaints management training that includes recognising, escalating, recording, investigating and responding to complaints within the appropriate timelines in accordance with the centre's Complaints Procedure.
• The PIC/Clinical Nurse Manager (CNM) will ensure that staff are aware of what constitutes a complaint and the need to record all expressions by residents or other of dissatisfaction in the electronic complaints log and to adhere to the correct procedures to ensure resident complaints are resolved to their satisfaction.
• The management team will screen all records of resident feedback, including minutes of resident meetings and daily progress records, to ensure that all complaints are identified, logged and addressed in line with Company policy.
• The PIC will ensure that all complaints are fully investigated, and that the outcome is communicated to the complainant in writing and will include details of the review process and guidance to the complainant about how to seek further review of a complaint at an Executive level if they remain dissatisfied with the response.
• The PIC will ensure that learning outcomes are recorded in the complaints log and that an appropriate quality improvement plan is developed and implemented where service improvements are indicated as a consequence of complaints.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The PIC will ensure that the identified area of flooring on corridor that is torn will be repaired / replaced.
• The PIC and Facilities Manager will conduct a review of all rooms within the home. Following this review a scheduled plan of works will be developed to address painting and repairs to wall surfaces.

• The ceiling leak that was identified on the day of inspection has been fully repaired.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• The PIC and CNM will monitor standards and systems of cleaning throughout the centre on daily walkabouts. Any deficits in cleaning standards will be brought to the attention of the housekeeping supervisor and where necessary a Quality Improvement Plan (QIP) will be developed.
• The PIC will ensure there is no inappropriate storage of equipment in the centre and that all equipment is safely and appropriately stored. All staff have been advised not to store any items in empty bedrooms. The PIC will monitor empty rooms as part of daily walkabout and any items stored inappropriately will be immediately removed.
• The PIC and Housekeeping Supervisor will complete a weekly walkabout to monitor cleaning standards in the centre.
• Cleaning schedules and findings from Hygiene Audits will be discussed at safety pause meetings, and at monthly management meetings. Corrective actions will be identified as part of the overall Quality Improvement Programme.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

• A Fire Safety Risk Assessment (FSRA) has been carried out by a Fire Consultant that includes a review of: alternative escape routes, emergency lighting, exit signage, external escape routes, location of assembly point. We have now received a formal report from the Fire Safety Consultant.
• We will review the findings of the FSRA in relation to integrity of fire compartments/containment and will develop a programme of works to address these issues.
• A fire safety Quality Improvement Plan (QIP) has been developed by the PIC and HCM.
• The PIC will ensure that the fire safety QIP is updated quarterly. Any high-risk items on the fire QIP will be discussed by the senior management team to ensure that appropriate mitigations are in place while the risk is being managed or eliminated.
• The PIC will ensure that the intumescent strips on fire doors are checked as part of routine maintenance checks in Home.

• The Facilities team will undertake works to address fire safety risks and these works will be prioritised, including external grounds, repair or replacement of fire doors as required sealing of attic hatch and the sluice room.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• The PIC / CNM will ensure that residents care plans are updated to reflect the assessed care needs of the residents.
• The PIC will ensure that residents assessments are completed accurately and reviewed / updated as necessary to ensure they reflect the current status of the resident, this information will be shared at handover and safety pause. This will include the accurate and timely assessment of residents' nutritional status and appropriate responses to significant weight loss, such as referral to a Dietitian and/or GP for consideration of food fortification or prescription of food supplements. The impact of such interventions will be evaluated and recorded to guide practice.
• For those residents with responsive behaviour issues, the PIC will ensure that appropriate assessments are carried out and the care plan is updated to ensure that the care interventions are appropriate. Responsive behaviour care plans will identify patterns or triggers to escalations in behaviours and appropriate distraction or de-escalation techniques to ensure all staff adopt a similar approach towards the care of the residents.
• The PIC will ensure that the care plan is developed only after a series of assessments are completed, the care plan will then be developed in consultation with the resident / representative.
• The care plan will focus on what matters to the resident and will incorporate the Age Friendly framework, the 4 Ms (what matters to me, medication, mentation and mobility).
• The PIC/CNM will complete a care plan audit monthly and develop a QIP as necessary, the results of which will be shared with nurses and used as an opportunity for learning.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will ensure that the residents' right to privacy, dignity and choice is always respected.
• A comprehensive review of rostering practice has been completed by the PIC with

regards to gender of care staff. Where practicable the roster will be completed to ensure there is an equal gender balance so that residents' preferences regarding gender of care staff providing personal care is always respected.
• As part of the daily walkabout the PIC will ensure that the table menus accurately reflect the choices available on the day.
• The privacy curtain identified on day of inspection has been repaired. The PIC will monitor privacy curtains in all twin rooms as part of daily walkabout and will replace as necessary.

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	31/03/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	31/01/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the	Substantially Compliant	Yellow	31/03/2026

	Authority are in place and are implemented by staff.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/03/2026
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	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 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	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 the incident within	Not Compliant	Orange	31/01/2026

	2 working days of its occurrence.			
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	31/01/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	31/01/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly	Not Compliant	Orange	31/01/2026

	recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/01/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/03/2026