



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Ealga Lodge Nursing Home
Name of provider:	Underhill Investments Limited
Address of centre:	Main Street, Shinrone, Birr, Offaly
Type of inspection:	Unannounced
Date of inspection:	13 October 2025
Centre ID:	OSV-0005665
Fieldwork ID:	MON-0047084

About the designated centre

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

Ealga Lodge Nursing home is located in Shinrone town centre. The centre is located in off the main road and is situated in a residential area. The centre is a purpose built 48 bed facility. The designated centre accommodates both female and male residents over the age of 18 years. Residents' accommodation is provided in 46 single and one twin bedroom with en suite facilities over two floors. The first floor is accessible by means of a lift and a stairs located in the reception area of the centre. Communal sitting rooms are provided on both floors and a dining room is available on the ground floor. Two enclosed courtyard areas with outdoor seating are available to residents. The service employs nurses, carers, activity, catering, household, administration and maintenance staff and offers 24 hour nursing care to residents. Ealga Lodge Nursing Home caters for residents with long-term, convalescence, respite, palliative and dementia care needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	46
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 13 October 2025	08:00hrs to 16:40hrs	Aoife Byrne	Lead
Monday 13 October 2025	08:00hrs to 16:40hrs	Niamh Moore	Support

What residents told us and what inspectors observed

The inspectors found that Ealga Lodge Nursing Home was a well-run centre where residents were supported to enjoy a good quality of life. Feedback from residents was that this was a very good place to live, and that they were very well cared for by staff who were kind and attentive to their needs.

This unannounced inspection was carried out over one day. There were 46 residents living in the centre on the day of the inspection. On arrival inspectors spent time walking through the centre, which provided an opportunity for inspectors to introduce themselves to residents and staff. Some residents were observed to be in the dining room having breakfast while others were in their bedrooms having breakfast in bed. Following the walk around there was an introductory meeting with the person in charge and the quality assurance lead.

Ealga Lodge is a purpose built two story premises located in Shinrone in Co. Offaly. The centre is registered to provide care for a maximum of 48 residents. The accommodation consists of four units on the ground floor named after past American presidents "Reagan", "Kennedy", "Obama", and "Clinton", with further accommodation on the first floor. The bedroom accommodation comprises of one twin bedroom and 46 single bedrooms. Residents' bedrooms were personalised with their individual possessions.

Overall the premises was bright and clean. Seasonal Halloween decorations were on display throughout the communal areas and this increased the warm and homely atmosphere in the centre. Residents had access to a number of communal day spaces on both the ground and first floors. These spaces on the ground floor were mostly in use on the day of the inspection, such as the large communal day room, a dining room, a smoking room. There was also access to an external enclosed courtyard which contained a water feature. On the day of the inspection, the large day room on the ground floor was a hub of action, where activities were seen to be hosted and visitors spent time with their loved ones. There was also an inner room from this day room, referred to as the activity room. The Health Service Executive were on site in this room on the day of the inspection, offering residents the flu and COVID-19 vaccinations. Many residents were seen to be supported to avail of this programme.

There was a display in the reception area to inform visitors and residents that the centre participates in the Caru programme for nursing homes. This programme is to ensure staff are supported in the delivery of palliative, end of life and bereavement care. The display also included information on "think ahead" which is a guide for advance care planning and end of life.

While there were adequate numbers of staff on duty, it was observed that during the morning time, the communal day room had up to 17 residents with no staff

present to assist the residents who were immobile and were not within reach of a call bell. Although the activities co-ordinator was seen assisting residents from the dining room to the day room, they were also allocated to carry out a "breakfast club" in the dining room during this time. Inspectors also noted on two occasions that staff did not use the designated staff facilities and instead took their breaks in the residents communal dining area.

On the day of inspection, the dirty utility room on the first floor was empty and was available for use by staff. This floor did not have clinical wash hand basins and staff informed the inspectors that they were using the staff room for hand hygiene. This is a repeat finding from May 2023. Management told the inspectors that the registered provider would review this. Inspectors observed that due to lack of storage available on this first floor, corridors were used as storage areas for items such as bins, and trolleys storing linen and items for personal care.

Since the previous inspection, the registered provider had commenced fire safety works to door frames, however many frames remained unfinished and some premises works remained outstanding such as painting, with areas of chipped paint work visible. Inspectors were told that contractors had commenced in March 2024, however the timeline for completion had extended beyond initial expectations. The registered provider had committed to complete these works by February 2025 in their compliance plan from the previous inspection.

Throughout the day of inspection, the atmosphere was relaxed and calm, and inspectors observed staff tending to residents' needs in a caring and respectful manner. The overall feedback received from residents was that residents were happy living in the centre and felt safe. Residents spoken with said there always seemed to be enough staff on duty to tend to their needs and they were not left waiting for their call bells to be responded to. However, one resident said that there are sometimes delays in accessing the full hoist. One resident told inspectors that "everyone is looked after" and "all the staff are good". Visitors spoken with were complimentary of the care that their family members received and the communication they received from staff, including that management were responsive to action any areas of feedback.

Residents were offered a choice of meals and frequent drinks and snacks were provided throughout the day. Inspectors observed the breakfast and lunch servings on the day of the inspection, and found there were sufficient staff available to provide assistance to residents, where required. Overall, from speaking with residents and from a review of records of residents' consultations, inspectors found that residents were satisfied with the food offered. One resident said "the food is very, very good".

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

Capacity and capability

This was an unannounced inspection carried out by two inspectors of social services to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up the compliance plan received from the previous inspection carried out in August 2024, unsolicited information received and statutory notifications submitted by the provider since the last inspection. Overall, the findings of this inspection was that residents received a good standard of care, however some improvements were required in the oversight systems to ensure the service was provided in line with the regulations.

Underhill Investments Limited comprises of three company directors and is the registered provider for Ealga Lodge Nursing Home. This nursing home is part of a wider group that has an established senior management structure in place, including a Group General Manager and a Quality and Assurance Lead. Both senior managers were present during this inspection, and evidence was seen in management meeting records that they provided governance and support to this designated centre.

Inspectors reviewed Schedule 5 policies and procedures and saw that these were in place and had been reviewed within the last three years. However, some policies had not been updated in line with the current practices within the nursing home, or with recent changes to the regulatory requirements.

The person in charge worked full-time in the designated centre. The person in charge was supported by a clinical nurse manager, nursing staff, healthcare assistants, activity staff, housekeeping, catering, maintenance and administrative staff. The registered provider was recruiting for four healthcare assistants, in the interim these staff vacancies were covered by temporary staff. Inspectors found that there was a sufficient number of staff available on the day including two nurses available day and night. Findings relating to the allocation of staff and resources which required review, are outlined under Regulation 23: Governance and Management.

The inspectors were provided with a hard copy directory of residents to review. Overall, this register was well-maintained and information relating to any temporary transfers and discharges were up-to-date. However, action was necessary to ensure it contained all information as required under Schedule 3 of the regulations.

The registered provider ensured that the required records for this inspection, including staff records set out in Schedule 2 and the duty roster as required in Schedule 4 were available. However, there were occasions on this inspection where residents' files were not being stored securely. This is further discussed under Regulation 21: Records.

The registered provider had monitoring systems in place to oversee the service such as meetings, auditing and a risk register. The registered provider had completed an annual review of the quality and safety of care delivered to residents in 2024 in accordance with the National Standards. There was evidence of consultation with residents, and an action plan put in place to respond to areas for improvement identified. However, inspectors found that the oversight measures did not consistently result in quality improvements, particularly in relation to the environment, including premises and fire precautions. This was further evidenced where the actions the registered provider had committed to addressing in their compliance plan of the August 2024 inspection had not been implemented on this inspection. This is further discussed under Regulation 23: Governance and Management.

Regulation 15: Staffing

On the day of the inspection there were sufficient numbers of staff on duty to meet the needs of the residents.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents did not include all criteria set out within Schedule 3 of the regulations. For example:

- The address of the resident's next of kin was not recorded in a sample of eight records reviewed.
- The name and address of any authority, organisation or other body which arranged the resident's admission was not recorded for any resident.

Judgment: Substantially compliant

Regulation 21: Records

Inspectors saw on two occasions where the store room which contained residents' files was unlocked and no staff present or in the vicinity meaning confidential information on residents were not secure. Inspectors brought this to the attention of the person in charge and this was rectified for the remainder of this inspection.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured that the resources available were in accordance with the statement of purpose. For example, the registered provider had committed to 0.18 whole time equivalent of occupational therapy/physiotherapy, of 6.48 hours a week. However, inspectors were told that there was no occupational therapist and the physiotherapist was only present in the centre for a maximum of four hours per week.

The findings of this inspection were that the oversight systems required strengthening to ensure all areas of the service were safe, appropriate, consistent and effectively managed. For example:

- The oversight of record management required improvement. For example, these systems did not ensure that residents' records were stored safely. In addition, a sample of four staff records set out under Schedule 2 of the regulations were reviewed, and one staff member did not have a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 prior to the commencement of their employment.
- Oversight systems had not ensured that the compliance plans from the previous inspection had been fully implemented, resulting in repeat findings under Regulations 17: Premises and Regulation 28: Fire Precautions.

The oversight of fire precautions required review:

- While there were monthly fire door inspections occurring, the frequency did not comply with the registered provider's policy, which specified these inspections must be completed weekly. The recorded reviews did not identify any fault of the fire doors, and this was not consistent with the inspectors findings at the time of this inspection.
- In addition, an evacuation aid used during fire drills was not included in or documented in the residents personal emergency evacuation plans (PEEP) or the fire safety procedure. Consequently, the provider failed to demonstrate assurances that appropriate oversight of risk and the necessary controls in place for this.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Not all policies were reviewed as required. For example, the risk management policy and safeguarding policy had not been updated to include the changes made to the regulations in March 2025. In addition, the medication policy and responding to emergencies policies were not reviewed to ensure they were specific to the centre.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that residents living in Ealga Lodge Nursing Home were receiving a good standard of care and support which ensured that they could enjoy a good quality of life. Notwithstanding the efforts made by the nursing and care staff to provide a good standard of care to the residents, inspectors found that outstanding actions from the previous compliance plan had not been fully addressed, resulting in the need for further improvements specifically in the areas of Regulation 17: Premises, Regulation 28: Fire Precautions and Regulation 13: End of life care.

Staff were observed to communicate appropriately with residents that had communication difficulties. Residents were afforded time to express themselves and were not rushed. A review of the residents' records showed that when a resident had a communication difficulty, it was appropriately assessed, and all relevant information was recorded in the resident's care plan.

There was evidence that the registered provider had taken measures to protect residents from abuse. All residents spoken with stated that they felt safe in the centre and staff were confident in their understanding of their role in relation to protecting residents from abuse.

While some areas of the centre were well presented and laid out to meet the needs of the residents, the registered provider had not ensured that the premises adhered to all matters within Schedule 6 of the regulations. Some of these areas were previously identified at the last inspection in August 2024 which the provider had committed to actioning as part of the compliance plan, such as poor storage and paintwork. This is further discussed under Regulation 17: Premises.

The registered provider had some good fire safety processes in place. For example, there was a fire safety management policy, fire safety equipment was provided and residents each had their PEEP stored within their bedrooms, however, the PEEP did not always contain the correct information. Fire safety works identified at the last inspection remained outstanding, these gaps in compliance are discussed under Regulation 28: Fire Precautions.

Overall there were good practices in medication management. Registered nurses were knowledgeable of their professional responsibilities in relation to medicines and

were seen to administer medicinal products in accordance with the directions of the prescriber.

Regulation 10: Communication difficulties

Residents that had communication difficulties and special communication requirements had these recorded in their care plans and were observed to be supported to communicate freely.

Judgment: Compliant

Regulation 13: End of life

Spirituality and end of life care plans reviewed were clinical in nature and did not outline resident's wishes with regards to the arrangements to be put in place when they reached their end of life. This meant that staff were not always aware of residents' end of life wishes, including their physical, emotional, social, psychological and spiritual needs.

Judgment: Substantially compliant

Regulation 17: Premises

The following areas required action to ensure that the premises promoted a safe and comfortable living environment for all residents. For example:

While the overall premises met the needs of the residents, some areas were not kept in a good state of repair, for example:

- Paintwork was seen to be chipped on some walls, door frames and at the nurses' station
- Wear and tear was observed to skirting boards and handrails throughout the corridors
- The ceiling in the linen room had a hole in the plasterboard and was exposed.

There was insufficient storage space, resulting in some items being stored inappropriately, for example;

- Zimmer frames and one residents comfort chair were stored in the residents activity room

- Personal items belonging to residents were required to be stored in an unlocked linen room.

Hand hygiene facilities were not available for staff on the first floor, this is not in line with best practice and national guidelines.

Judgment: Substantially compliant

Regulation 26: Risk management

While there was a risk management policy in place, it did not fully meet the criteria of the regulations. For example, it did not contain the following:

- Arrangements for the identification, recording and investigation of serious incidents or adverse events involving residents.
- A process for the implementation of actions and recommendations arising from a serious incident or adverse event.
- A process for the audit, review and learning from events.
- The measures and actions in place to control the risk of infectious diseases.

Judgment: Not compliant

Regulation 28: Fire precautions

While there was evidence that the registered provider had taken some precautions against the risk of fire. The arrangements for preventing, containing and responding to a fire required review.

This was evidenced by;

- Inappropriate storage of flammable and combustible materials. For example, a store room contained oxygen and also some high risk flammable products such as aerosol sprays and alcohol hand sanitiser. The corridors on the first floor were used as storage areas for flammable items such as linen and bins.
- A number of fire doors were observed to have gaps, and some doors which did not close fully. Additionally, fire stopping works to door frames committed to be completed by February 2025 in the registered provider's compliance plan following inspection in August 2024, were ongoing on the day of the inspection. The registered provider did not have a time frame for when these works would be completed. This meant that some areas had doors which were not capable of restricting the spread of smoke and fire.
- The fire evacuation procedures known to staff were not reflected in residents records or in the providers fire safety policy. For example, while PEEPs and

fire drills outlined that residents' wheelchairs were used for transport in an emergency, inspectors were told the practice was to transport residents using a commode chair. Inspectors were told that this equipment was used to move residents to the next compartment, and in the event of a full evacuation, the resident would be transferred from the commode chair to a wheelchair. However, this process was not part of the registered providers evacuation policy nor had it been trialled, and therefore there was a lack of assurances that staff working in the centre were aware of or competent in the correct procedure to be followed in the case of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medication management processes such as the ordering, prescribing, storing, disposal and administration of medicines were safe and evidence-based.

The inspectors observed good practices in how the medicine was administered to the residents. Medicine was administered appropriately, as prescribed and dispensed.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff. Inspectors reviewed a sample of closed safeguarding concerns and it was evident that they were investigated appropriately.

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	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ealga Lodge Nursing Home OSV-0005665

Inspection ID: MON-0047084

Date of inspection: 13/10/2025

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: <ul style="list-style-type: none"> The directory of residents will be updated to include next-of-kin addresses and the authority, organisation or body arranging each resident's admission, where applicable. 	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: <ul style="list-style-type: none"> Ensuring controlled access to the records storeroom has been reinforced with relevant staff, ensuring the door remains locked when records are not being actively accessed. 	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: <p>Actions covered under Regulation 17 – Premises</p> <ul style="list-style-type: none"> An updated premises maintenance schedule will be implemented to address areas of wear and tear, including chipped paintwork, damaged skirting boards, handrails and ceiling finishes. 	

- Storage arrangements will be reviewed to ensure resident areas are not used for inappropriate storage.
- Equipment such as linen and personal care trolleys are used during care delivery and returned to designated storage areas following completion of care routines. Where temporary positioning is required due to operational need, this is monitored to ensure corridors and escape routes remain clear and safe.
- Waste disposal arrangements have been reviewed to support infection prevention and control at the point of care, while ensuring bins are positioned appropriately at the end of the corridors, and do not obstruct corridors, fire exits or access routes.
- Hand hygiene facilities for staff on the first floor are being addressed to ensure staff have access to handwashing facilities.

Actions covered under Regulation 28 – Fire Precautions

- The storage of flammable and combustible materials has been reviewed, and appropriate arrangements are now in place to ensure such materials are stored safely. Corridors and escape routes are maintained clear at all times.
- All identified fire door and fire stopping works have now been completed.
- Fire door inspections will be carried out on a monthly basis, with findings recorded and actions followed up.
- Evacuation equipment used during fire drills has been reviewed. Commode chairs are no longer used for evacuation purposes, and evacuation procedures now align with the equipment documented in residents' Personal Emergency Evacuation Plans (PEEPs).

Actions covered under Regulation 21 – Records

- Ensuring controlled access to the records storeroom has been reinforced with relevant staff.
- The records storeroom door remains locked when records are not being actively accessed.

Staff Files

- All staff members currently working in Ealga Lodge have Garda Vetting on file
- Moving forward, no staff member will commence duty in the centre until Garda vetting has been returned, reviewed, and deemed satisfactory in line with Schedule 2 requirements.

Resources

- Governance oversight arrangements will continue to ensure that resources available within the centre support the effective delivery of care in line with residents' assessed needs.

Regulation 4: Written policies and procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</p> <ul style="list-style-type: none"> • Relevant policies, including safeguarding, medication management and responding to emergencies, have been updated to reflect current regulatory requirements and the March 2025 regulatory changes and to ensure centre-specific application. 	
Regulation 13: End of life	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 13: End of life:</p> <ul style="list-style-type: none"> • End-of-life care plans will be updated to include a more detailed, person-centred section outlining residents' wishes and preferences. 	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <ul style="list-style-type: none"> • An updated premises maintenance schedule will be implemented to address areas of wear and tear, including chipped paintwork, damaged skirting boards, handrails and ceiling finishes. • Storage arrangements will be reviewed to ensure resident areas are not used for inappropriate storage. • Equipment such as linen and personal care trolleys are used during care delivery and returned to designated storage areas following completion of care routines. Where temporary positioning is required due to operational need, this is monitored to ensure corridors and escape routes remain clear and safe. • Waste disposal arrangements have been reviewed to support infection prevention and control at the point of care, while ensuring bins are positioned appropriately at the end of the corridors and do not obstruct corridors, fire exits or access routes. • Hand hygiene facilities for staff on the first floor are being addressed to ensure staff have access to handwashing facilities. 	

Regulation 26: Risk management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management:</p> <ul style="list-style-type: none"> • The provider acknowledges that while risk management policies, procedures and systems are in place and operational within the centre, further clarity is required to demonstrate how these arrangements link together to meet the requirements of Regulation 26. The actions outlined below will support greater clarity and in relation to risk management arrangements and ensure that the centre's existing systems are clearly demonstrated as meeting the requirements of Regulation 26. <p>Actions to be undertaken:</p> <ul style="list-style-type: none"> • The centre will clearly outline its overarching risk management framework to demonstrate how risks are identified, assessed, recorded, investigated, and reviewed from initial occurrence through to governance oversight. • The processes for managing incidents and adverse events will be clearly described to show how actions are identified, implemented, monitored, and reviewed, and how learning from incidents informs ongoing practice. • The measures in place to manage the six specified risks under Regulation 26 will be clearly signposted within the risk management framework, with reference to the relevant existing policies and procedures. • Governance oversight of risk management will be clearly outlined to demonstrate how incidents, trends and emerging risks are reviewed at management level and escalated as required. • Existing risk registers, incident reporting systems and governance meetings will continue to be used to monitor patterns, review controls and ensure risks are managed consistently and effectively. 	
Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <ul style="list-style-type: none"> • The storage of flammable and combustible materials has been reviewed, and appropriate arrangements are now in place to ensure such materials are stored safely. Corridors and escape routes are maintained clear at all times. • All identified fire door and fire stopping works have now been completed. • Fire door inspections will be carried out on a monthly basis, with findings recorded and actions followed up. • Evacuation equipment used during fire drills has been reviewed. Commode chairs are no longer used for evacuation purposes, and evacuation procedures now align with the equipment documented in residents' PEEPs. 	

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	31/03/2026
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with	Substantially Compliant	Yellow	30/06/2026

	the statement of purpose prepared under Regulation 3.			
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	28/02/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	13/10/2025
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.	Substantially Compliant	Yellow	13/10/2025
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	30/06/2026
Regulation 26(1)(c)(vi)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to	Not Compliant	Orange	31/03/2026

	control infectious diseases.			
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording and investigation of serious incidents or adverse events involving residents.	Not Compliant	Orange	31/03/2026
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the implementation of actions and recommendations arising from subparagraph (d).	Not Compliant	Orange	31/03/2026
Regulation 26(1)(f)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the audit, review and learning from events.	Not Compliant	Orange	31/03/2026
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to	Substantially Compliant	Yellow	31/03/2026

	control accidental injury to residents, visitors or 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.	Substantially Compliant	Yellow	30/11/2025
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	31/12/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2026
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may	Substantially Compliant	Yellow	20/10/2025

	require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
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