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:	Regina House Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Cooraclare Road, Kilrush, Clare
Type of inspection:	Unannounced
Date of inspection:	05 February 2026
Centre ID:	OSV-0000612
Fieldwork ID:	MON-0049427

About the designated centre

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

Regina house community nursing unit is located on the outskirts of the town of Kilrush in West Clare. The centre is single storey and designed around a central, secure, enclosed garden, which was easily accessible from the corridors and day room areas. It can accommodate up to 30 residents over the age of 18 years. It is a mixed gender facility catering from low dependency to maximum dependency needs. It provides long-term residential, respite, dementia and palliative care. Bedroom accommodation is offered in 18 single and six twin rooms. Nine single bedrooms and five twin rooms have ensuite shower and toilet facilities. Nine single bedrooms in the older section of the building can accommodate residents who do not require the assistance of mechanical devices to mobilise. There was a variety of communal day spaces, including dining room, day rooms, quiet room, church, front entrance area, conservatory and family room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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
Thursday 5 February 2026	09:30hrs to 17:15hrs	Sharon Kane	Lead
Thursday 5 February 2026	09:30hrs to 17:15hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

From what the residents told us and what the inspectors observed, it was clear that the residents' enjoyed a good quality of life. There was a calm and relaxed atmosphere within the centre, as evidenced by residents moving freely and unrestricted throughout the centre. It was evident that management and staff knew the residents well and were familiar with each resident's daily routine and preferences. Those residents who could not communicate their needs appeared comfortable and content. Staff were observed to be kind and compassionate when providing care and support, delivering care in a respectful and unhurried manner.

Following an introductory meeting with the person in charge, inspectors completed a tour of the building, providing an opportunity to review the living environment and to meet with residents and staff. Residents were observed to be up and about in various areas of the centre. Some residents were having breakfast, some were relaxing in communal areas, while others were having their care needs attended to by staff. It was noted on the tour that several cross-corridor fire doors did not close fully and there was visible gaps between doors when closed.

Regina House Community Nursing Unit was situated in the town of Kilrush, County Clare. The centre was a single-storey purpose-built facility which provided accommodation for 30 residents. This unannounced inspection took place over one day.

The centre was laid out to meet the needs of residents. Bedroom accommodation consisted of single and twin bedrooms, which were spacious and provided residents with adequate space to store personal belongings. Many bedrooms were personalised with photos, artwork and soft furnishings. The centre was warm, bright and homely. There was a variety of communal rooms available in the centre including a visitor's room, a conservatory and a chapel. Overall, the centre was clean and tidy; however, some areas of maintenance, namely floor coverings in two areas and some walls appeared to be in a poor state of repair. Residents had access, from several areas of the centre, to an accessible and attractive internal courtyard garden, which was laid out with furniture and flower beds.

Residents spoken with indicated that they had choice and freedom to spend their day as they wished. One resident stated they could come and go as they pleased. Another described enjoying spending time in their room instead of the day room and said that staff would always stop into them when they were walking by doing their duties; inspectors observed this happening on the day of inspection. Residents described being very happy in the centre, stating that they "couldn't say one bad thing about the place or the people in the centre". Another resident described finding it difficult to make the decision to come to a nursing home but was glad they made the decision as they felt "safe and well-minded".

Some residents were observed participating in activities in the day room throughout the day. Other residents were observed spending time in their bedrooms, while others were receiving visitors in other communal areas. When spoken with, residents described having plenty to do in the day and one resident described really enjoying the magic table and music. A charity group, linked to the centre, provided funds for activity equipment.

Visitors were observed coming and going throughout the day. Visitors spoken with described "loving" the centre. They stated that they were delighted when their family member was offered a place in the centre. They described staff as attentive and kind, and that they knew residents family members' by name when they visited. They stated that they couldn't find "one fault" with the centre and would recommend it to anyone.

The dining experience was observed to be a social occasion for residents. The dining tables were set and laid out pleasantly. The atmosphere in the dining room was calm and unhurried. Residents were complimentary about the food served in the centre, and confirmed that they were always afforded choice. Staff were observed engaging with residents during meal times, and provided discreet assistance and support to residents, where required.

The following sections of this report detail the findings with regard to the capacity and capability of the centre, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced monitoring inspection carried out by 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). There were 24 residents accommodated in the centre on the day of the inspection and 6 vacancies. The findings of the inspection reflected a service that provided person-centred care and positive outcomes for residents in an inclusive environment. The governance and management was well-organised, and the provider ensured that residents were supported to have a good quality of life. However, this inspection also found that the management of fire safety systems did not comply with the requirements of the regulations.

The registered provider of this centre was the Health Service Executive (HSE). There was a clearly defined organisational structure in place, with identified lines of responsibility and accountability at individual, team and organisational level. The person in charge facilitated this inspection and they demonstrated a good understanding of their role and responsibility. They were visible in the centre and were well known to the residents. They were supported in their role by a clinical nurse manager, who deputised in their absence. The staffing complement included

nurse, healthcare assistants, activity staff, catering staff, maintenance and cleaning staff.

There were clear roles and responsibilities established within the management structure, that identified the lines of authority and accountability for all areas of care provision. Management oversight systems were in place which included meetings, a risk register and auditing. A sample of audits reviewed included care plan audits and pressure ulcer audits. Action plans were developed and completed, where areas for improvement were identified. However, inspectors found that the oversight structures in place did not always identify areas of risk, such as fire precautions.

On the day of inspection, there was sufficient levels of staffing in the centre with appropriate skill mix. Staff were observed working as a team. There was an ongoing recruitment plan in place, and the provider had recently recruited additional nursing staff. Agency staff were used as an interim arrangement. Communal areas were appropriately supervised, and inspectors observed kind and person-centred interactions between staff and residents. Inspectors reviewed a sample of staff files. The files contained the necessary information, as required by Schedule 2 of the regulations including evidence of a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Staff had access to a suite of educational programmes including infection prevention and control, fire safety, manual handling, safeguarding and responsive behaviours. A review of the training matrix indicated that all training was up-to-date, and further training was scheduled to take place. Staff spoken with confirmed that they had received mandatory training including fire safety, manual handling and safeguarding.

The provider had contracts for the provision of services in place for residents, which detailed the terms on which they resided in the centre.

The provider had ensured that a contract of insurance against injury to residents was in place.

Notifications, as set out in Schedule 4 of Care and Welfare Regulations, were reported to the office of the Chief Inspector, as required.

There was a complaints policy in place in the centre and the procedure was available to view in the lobby of the centre. A review of the complaints log indicated that complaints received were dealt with in a timely manner and the complainant's satisfaction with the resolution of the complaint was recorded. Residents spoken with on the day of the inspection knew who they could talk to if they had a complaint.

Regulation 15: Staffing

There were sufficient numbers of staff available, with the required skill mix, to meet the assessed needs of the residents in the designated centre, on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to mandatory training, and staff had completed all necessary training appropriate to their role. Arrangements were in place to ensure staff were appropriately supervised to carry out their duties through senior management support and presence.

Judgment: Compliant

Regulation 22: Insurance

The provider had ensured that a contract of insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place did not fully ensure that the service provided was safe, appropriate and effectively monitored. For example;

- The monitoring and oversight of fire safety was not effective, and did not ensure the safety and well-being of the residents.
- The centre's risk register did not contain known risks such as identified issues with fire doors and the need to replace the fire control panel. This meant that actions to mitigate and manage risks to residents had not been identified or managed.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The provider had contracts for the provision of services in place for residents, which detailed the terms on which they resided in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

A review the incident log found that the person in charge of the designated centre had notified the Chief Inspector of adverse incidents, in line with the requirements of Schedule 4 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in place which met the requirements of Regulation 34.

Judgment: Compliant

Quality and safety

The findings on the day of inspection were that the provider was delivering satisfactory care to residents, in line with their assessed needs. Residents had access to health care services, including medical practitioners, speech and language therapy, physiotherapy, and tissue viability nurses. Clinical risks, such as nutrition and infection control were monitored. Residents' spoke highly of the quality of the service provided and reported feeling safe living in the centre. However, this inspection found that issues relating to fire precautions, and aspects of the premises did not fully align with the requirements of the regulations.

Inspectors reviewed the fire safety systems in the centre. Regular fire equipment safety checks were carried out in the centre. Staff spoken with demonstrated appropriate knowledge of the fire evacuation procedure, and described attending and participating in fire drills. On a walk around of the centre, inspectors observed that several cross corridor fire doors were observed to not close completely, leaving gaps visible between doors. This could impact the effectiveness of the fire door to contain smoke and fire, in the event of a fire emergency. The registered provider had commissioned a fire safety report in relation to the fire doors in 2024. This

report identified a number of deficits in 80 fire doors in the centre. However, no action had been taken to address the deficits in the fire doors at the time of this inspection. In addition, a review of a service record relating to the fire detection panel found that recommendations had been made to upgrade the panel in 2022, however, no action had been taken. Every resident in the centre had a Personal Emergency Evacuation Plan (PEEP) in place, however, inspectors found that these plans were not easily accessible to staff, and therefore may not be accessible to staff or emergency services, in the event of an emergency.

There was inadequate storage in the centre. Inspectors observed that communal rooms were used to store some equipment, and other equipment was stored in resident treatment rooms. Inspectors also found that there was areas in the centre that were in a poor state of repair. There was damage to the floor coverings and wall surfaces in some residents' bedrooms, which meant that they were not amenable to cleaning.

Inspectors reviewed a sample of assessments and care plans and found that care plans were not always updated to reflect the current care needs of the residents'. Consequently, some care plans did not consistently provide person-centred, evidence-based guidance on the current care requirements of the residents. In addition, some residents did not have the social aspect of their care plans developed following assessment.

Residents had access to adequate quantities of food and drink. Residents had a choice of meals from a menu that was updated daily. Snacks and refreshments were available throughout the day. Residents spoken with were very complimentary of the food in the centre, and described how the menu choices changed recently, and that they were happy with the new options. Many residents attended the dining room for their lunch, while others chose to have lunch in their bedrooms. There were adequate numbers of staff available to residents that required assistance. These residents were supported to enjoy their meal in a kind and dignified manner.

Residents had access to their General Practitioner (GP) regularly, and as required. Arrangements were in place for residents to access the expertise of health and social care professionals for assessment and treatment, as required. This included access to the services of speech and language therapy, physiotherapy, and tissue viability nurses.

There was a low use of restrictive practice in the centre, and restrictive practices were appropriately risk-assessed and monitored. Residents who experienced responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) received evidence-based care and support from staff that was kind and respectful.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. Residents

reported that they felt safe living in the centre. The provider did not act as a pension agent for any resident.

Visitors were observed coming to the centre without restriction, and there was a variety of communal spaces where residents could receive their visitors. Visitors spoken with on the day of the inspection advised that visiting was facilitated day and night.

Residents had adequate storage space in their bedrooms for their possessions and had full access and control over their belongings.

Regulation 11: Visits

Visiting arrangements were flexible, with visitors being welcomed into the centre throughout the day of the inspection. Residents who spoke with inspectors confirmed that they were visited by their families and friends.

Judgment: Compliant

Regulation 12: Personal possessions

Inspectors found that residents living in the centre had appropriate access to, and maintained control over, their personal possessions.

Judgment: Compliant

Regulation 17: Premises

There were areas of the building that did not meet the requirements under Schedule 6 of the regulations, For example:

- There was insufficient storage space for equipment, resulting in the inappropriate storage of equipment, such as a hoist and resident specialist seating in resident treatment rooms and a fridge in a communal room.
- Paintwork was scuffed in a small number of resident bedrooms.
- Floor covering was damaged in two resident bedrooms.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents had access to adequate quantities of food and drink, including a safe supply of drinking water. A varied menu was available daily providing a range of choices to all residents including those on a modified diet. Residents were monitored for weight loss and were referred to dietetic services, when required. There were sufficient numbers of staff to assist residents at mealtimes.

Judgment: Compliant

Regulation 28: Fire precautions

The provider did not have adequate arrangements in place for the containment of fire. Several cross corridor fire doors did not form an effective seal when closed. This may impact on the effectiveness of the fire doors to contain fire, smoke or fumes.

In addition, safety systems in place to detect fire and evacuate residents were not robust, and could cause delay in the event of a fire emergency. For example:

- Personal emergency evacuation plans (PEEPS) were recorded for all residents', however, they were not easily accessible to all staff.
- A review of the servicing records for the fire detection panel found that there was an outstanding fault that had not been addressed. This may impact on the effectiveness of the system in alerting the centre's staff and residents if a fire were to occur.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans had not been developed for residents with an assessment of an identified need. For example;

- A social care assessment was completed for all residents. However, a review of a sample of care plans found that some did not have a social care plan developed to address their assessed needs, preferences and wishes.
- A resident with assessed nutritional needs did not have a nutritional care plan developed. This meant that staff did not have access to a care plan based on the assessed need of the resident, ensuring consistent and high quality care.
- A resident who was using a restrictive practice did not have a care plan developed, based on an assessment of need. This meant that staff did not

have access to a care plan regarding the use of the restrictive practice.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to general practitioners (GP), specialist services and health and social care professionals such as physiotherapy, dietitian and speech and language therapy, as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There were policies and procedures in place to support the management of responsive behaviours.

There was a low number of restrictive practices in use in the centre. Appropriate risk assessments were completed prior to the implementation of restrictive practices, and these were reviewed regularly.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Staff had access to training, and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse.

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 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Regina House Community Nursing Unit OSV-0000612

Inspection ID: MON-0049427

Date of inspection: 05/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

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

Governance and management:

1.Immediate Fire Safety Review and Escalation

Following the inspection, a comprehensive on site review was carried out involving the Person Participating in Management (PPIM), the Estates Manager, the Fire Safety Officer, and centre management.

An external fire safety company was formally engaged to complete a full re assessment of all fire doors, including:

- Integrity and compliance checks
- Identification of non compliant doors
- Confirmation of required remedial works

All concerns identified during this review were immediately risk assessed, and mitigation measures were put in place without delay.

2. Fire Drills Completed to Reflect Actual Risk Profile

Given the defective door sets, the centre adapted its drills to reflect the extended evacuation distances required.

Fire drills were completed using:

- Maximum resident numbers for each impacted compartment
- Night time staffing profiles
- Horizontal and progressive evacuation pathways adjusted for interim safety

This ensures staff are trained under realistic, risk reflective conditions, and residents remain safe during the remediation period.

3. Risk Register Updated

The centre conducted an immediate review of its risk register following the inspection. The following risks have now been added, assessed, and escalated:

- Non compliant or defective fire doors
- Requirement to replace the fire panel
- Resulting increased evacuation distances during interim period
- Associated dependency on temporary mitigation measures

4. Funding and Repair Programme
Funding has been approved to progress replacement and repair works identified during the external review.
A compliant contractor has been engaged, and the centre is awaiting a confirmed commencement date for the works.
This programme includes:
• Replacement/repair of all identified fire doors
• Full replacement of the fire control panel
• Verification of compartmentalisation standards following works
All works will be monitored at the Estates and Local QPS Meeting.
5. Ongoing Monitoring and Future Assurance
To prevent re occurrence of governance gaps in fire safety oversight, the following systems are now in place:
Six Monthly Review
A formal multidisciplinary meeting will occur where escalated actions will be discussed and addressed. Membership to include:
• Estates
• PPIM/PIC
• Maintenance
• Senior Nursing Management
Monthly Management Monitoring
The PIC will review:
• Drill schedules
• Compartment occupancy
• Staffing arrangements
• All outstanding remedial actions
• Integrity of interim mitigation controls
6. Compliance Timeline
• External review completed – Completed
• Risk register updated and escalated – Completed
• Fire drills conducted using updated risk profile – Completed & ongoing
• Contractor engaged for remedial works – Completed
• Repair works commencement – Awaiting contractor date
• Full compliance – On completion of works and verification

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Storage Deficits and Inappropriate Equipment Location
Issue Identified:
There was insufficient storage space, leading to inappropriate storage of equipment such as a hoist and specialist seating in treatment rooms, and a fridge located in a communal room.

Actions:
• A full review of storage capacity was completed by the PIC.
• Additional storage solutions have been identified and repurposed areas allocated solely for equipment storage.
• All clinical equipment has now been relocated to designated storage areas in line with infection prevention and safety requirements.
• The fridge previously stored in a communal space has been moved to an appropriate staff only area.
Ongoing Controls:
• Monthly environmental walk arounds will ensure storage practices remain compliant.
Timeline:
Completed and ongoing monitoring.
2. Scuffed Paintwork in Resident Bedrooms
Issue Identified:
Paintwork was scuffed in a small number of resident bedrooms.
Actions:
• A detailed assessment of all affected bedrooms has been completed.
• These areas have been identified for painting to be completed by external contractor.
• Painting works will be completed alongside the broader premises improvement programme.
Timeline:
Painting works scheduled for completion by Q3 2026.
3. Damaged Floor Coverings in Two Resident Bedrooms
Issue Identified:
Flooring was damaged in two bedrooms and required repair or replacement.
Actions:
• The Maintenance officer, PPIM and PIC carried out an on site review to assess the condition of each floor.
• Quotes have been requested for the replacement of the floor in the two areas.
• Funding has been approved for the replacement of the floor
• Awaiting confirmation of the contractor and commencement dates of the works.
Timeline:
Flooring repairs will be completed by Q3 2026.
4. Assurance and Ongoing Monitoring
• The centre's risk register has been updated to include all identified premises risks, including flooring deterioration and environmental wear, ensuring appropriate oversight and escalation.
• The provider will conduct six monthly premises reviews to ensure the environment remains safe, adequately maintained.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The provider acknowledges the deficits identified during the inspection in relation to fire containment, the maintenance of fire safety systems, and the accessibility of evacuation information. Immediate and sustained actions have been implemented to ensure full compliance with the regulations and to safeguard residents, staff and visitors.
1. Fire Containment – Cross Corridor Fire Doors
Inspection Finding:
Several cross corridor fire doors did not form an effective seal when closed, compromising the centre's ability to contain fire, smoke or fumes.
Actions Taken:
• A full repeat inspection of all fire doors was requested and completed by an external competent fire safety company.
• A detailed report was received identifying specific defective doors requiring repair or replacement.
• Instructions have now been issued to the contractor to commence this work, and the provider is awaiting a confirmed start date for completion of the repairs/replacements.
• In the interim, risk mitigation measures have been put in place, including:
• Adjusted evacuation procedures to account for potentially larger compartments
• Increased staff awareness and monitoring
• Prioritised evacuation routes adapted to reflect the defective door sets
• Risk assessments have been completed for each affected area and added to the risk register, with escalation to Senior Management and Estates for oversight.
• Timeline:
Works to be completed by the end of Q3 2026
2. Fire Detection and Alarm System – Outstanding Panel Fault
Inspection Finding:
A servicing record review found a fault on the fire detection panel that had not been addressed. It is to be noted that the fire panel is operational and functional but has reached the end of its life and decision has been made to fully replace the fire panel, rather than repair the existing unit.
Actions Taken:
• The fire panel fault was escalated immediately to Estates and the Fire Safety Officer.
• A decision has been made to fully replace the fire panel, rather than repair the existing unit.
• Funding approval has been secured, and the provider is awaiting the installation date from the contractor.
• The fault has been risk assessed, with compensatory safety measures in place until replacement is completed.
• Daily checks are being undertaken by nursing management and maintenance personnel.
• Timeline:
Fire panel replacement scheduled for the end of Q3 2026
3. Personal Emergency Evacuation Plans (PEEPs)
Inspection Finding:
PEEPs were completed for all residents but were not easily accessible to all staff in an emergency.
Actions Taken:
• All individual PEEPs remain in each resident's clinical file and are always accessible to all staff.

• A one page summary PEEP sheet for every resident is now stored in the Fire Emergency Grab Bag, carried by:
• The Person in Charge or deputy
• The designated Fire Marshal during any evacuation or drill
• This summary document outlines:
• Evacuation method
• Level of assistance required
• Equipment needed
• Priority/sequence for evacuation
• The summary PEEP list is updated weekly or sooner if:
• New admission
• Discharge
• Change in mobility or dependency
• Staff have been re briefed on the location and use of the PEEP summary.
• Outcome:
PEEP information is now immediately accessible during both day and night time emergencies.
4. Fire Drills – Updated to Reflect Actual Risk Profile
Actions:
• Fire drills have been conducted using updated evacuation routes and assuming extended travel distances due to defective fire doors.
• Drills have been completed with maximum compartment occupancy and night time staffing levels, ensuring the system can be safely implemented in real conditions.
• All drills are documented and reviewed after each event.
5. Ongoing Monitoring and Governance
To prevent recurrence and ensure robust fire safety control:
• Regular scheduled meetings will be completed involving Estates, Maintenance, the PPIM and HOS
• Monthly fire safety checks by a suitably qualified person will continue, including:
• Door integrity
• Alarm checks
• PEEP accessibility
• The risk register is updated and reviewed at discussed at the local QPS committee.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The provider acknowledges the deficits identified during the inspection in relation to the development of care plans following assessment. Immediate actions have been taken to ensure that all residents have comprehensive, individualised, and up to date care plans that guide safe, consistent, and person centred care.

1. Social Care Plans Not Developed Following Social Care Assessments
Inspection Finding:
Social care assessments had been completed for all residents, but some residents did not have social care plans that reflected their assessed needs, preferences, or wishes.
Actions Taken / In Progress:
• A staff meeting was held to highlight the compliance gaps in care planning and to reinforce the requirement for social care assessments to translate into actionable and individualised care plans.
• The PIC and CNM team have commenced the development of social care plans for all residents, ensuring these plans now reflect:
• Each resident's stated preferences
• Social, recreational, and psychosocial needs
• Values, cultural considerations and desired daily routines
• All social care plans will be fully completed by 30 April 2026.
Ongoing Monitoring:
• All assessments and care plans will continue to be reviewed 4 monthly/or in the event of changes. Monthly care plan audits will continue as per audit schedule
2. Nutritional Care Plan Not Developed for a Resident with Identified Nutritional Needs
Inspection Finding:
A resident with assessed nutritional needs did not have a corresponding nutritional care plan, which meant staff did not have clear guidance for consistent care delivery.
Actions Taken:
• A full review of all residents with nutritional assessments was completed.
• Nutritional care plans are currently being developed using information from validated assessments (e.g. MUST score, dietitian recommendations, weight trends).
• These care plans will detail:
• Required dietary modifications
• Monitoring frequency
• Assistance needs
• Fluid/nutritional supports
• All nutritional care plans will be completed by 30 April 2026.
Ongoing Monitoring:
• The dietitian's recommendations and weight monitoring trends will form part of the monthly clinical audit cycle.
3. Restrictive Practice Care Plan Missing for a Resident Using a Restrictive Measure
Inspection Finding:
A resident using a restrictive practice did not have a care plan based on an assessment of need.
Actions Taken:
• An audit of the care notes for all residents listed on the restraint register has been completed.
• All restrictive practice care plans are now in place, up to date, and include:
• The assessed need for the restrictive practice
• Alternatives trialled
• Duration and frequency of use
• Monitoring requirements
• De escalation and least restrictive strategies
• Care plans now reflect restraint reduction principles.
Ongoing Monitoring:

• Restrictive practice care plans will continue to be reviewed 4 monthly or in the event of change circumstances to the residents. The restraint register will continue to be reviewed daily by the CNM/Person in Charge and updated immediately if changes occur.

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	30/09/2026
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.	Substantially Compliant	Yellow	30/09/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/09/2026
Regulation 28(2)(i)	The registered provider shall make adequate	Not Compliant	Orange	30/09/2026

	arrangements for detecting, containing and extinguishing fires.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	30/04/2026