



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

Issued by the Chief Inspector

Name of designated centre:	Heather House Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	St Mary's Health Campus, Gurranabraher, Cork
Type of inspection:	Unannounced
Date of inspection:	17 February 2026
Centre ID:	OSV-0000714
Fieldwork ID:	MON-0049393

About the designated centre

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

Heather House Community Nursing Unit is a purpose built, two storey premises. It is located on the grounds of St. Mary's Health Campus on the north side of Cork City. It was opened in 2011 and a 60-bedded extension was added in 2023. The centre is currently registered to accommodate 60 residents in two units, namely, Poppy and Lily in the new extension as two units in the original building, Daisy and Primrose, are temporarily closed. Lily and Poppy are 30-bedded units. Each unit has its own sitting room, dining room and quiet room. Additional communal space include the quiet visitors' room alongside the main entrance, the prayer room, Glass room, main activities room and the Waterlily games room. Residents have free access to an enclosed garden with seating and walkways and a sheltered smoking area. Heather House Community Nursing Unit provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	59
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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
Tuesday 17 February 2026	09:30hrs to 18:30hrs	Erica Mulvihill	Lead
Tuesday 17 February 2026	09:30hrs to 18:30hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out over one day by two inspectors of social services. The inspectors found that the residents accommodated in the centre experienced a good quality of life and were supported by kind and caring staff that were knowledgeable of their needs. The inspectors met with most of the 59 residents living in the centre and spoke with nine residents in more detail, to gain an insight into their quality of life in Heather House Community Nursing Unit. Feedback from residents was overwhelmingly positive about the care they received and the compassion of the staff working there. One resident told the inspectors "we are lucky to have such responsive staff, they are always there to help" and another resident stating " we are well looked after" and " I wouldn't want to be anywhere else". One of the inspectors had the opportunity to meet with four visitors during the inspection, who commented overall about the lovely facility and great care received by their relatives.

On entering the centre, the inspectors were made aware that there was an outbreak of Influenza detected the previous evening and the management team had effectively implemented their outbreak contingency planning. The centre was in communication with the Department of Public Health regarding same. The inspectors complied with the guidance in place and followed the infection control precautions in place.

The inspectors walked around the centre with the Interim Person in Charge to meet with residents and staff and saw that the centre was a very well ventilated, clean and bright premises. Directional signage was clear and the inspectors saw that many residents' rooms were personalised with family pictures and items of significance to residents. Comfortable seating was provided in all bedrooms, and all rooms had ensuite toilet and shower facilities. There were sufficient storage in each bedroom for residents' belongings.

Heather House Community Nursing Unit is a 60 bedded centre, over two floors. Poppy and Lily unit each contained 30 single bedrooms. The registered provider had recently submitted an application to vary condition one and three of the centres registration to register the refurbished Primrose (dementia specific unit). Daisy unit on the first floor remained closed for refurbishment and was appropriately sealed prohibiting unauthorised entry as well as protection regarding risk associated with dust particles. The main entrance is wheelchair accessible and opens into an expansive hallway with Lily and Poppy units accessed to the right and the part of the centre under refurbishment and the renovated Primrose unit to the left.

The inspectors saw that the provider had invested time and resources in making the centre as homely as possible. For example, the corridors were decorated with framed aerial photographs of different parts of Cork City and had comfortable seating throughout the communal spaces. The "Glass Room" which had large

pictorial windows which had panoramic views of the city and surrounds was decorated tastefully and was a quiet space where residents could access freely as per their preferences. The centre had large communal spaces including day rooms, dining room and balcony areas on both floors accessible to residents through the main day room. The main activities room in the centre was currently not being used, as activities were being held in the day rooms of both units. The person in charge stated when Primrose and Daisy ward would re-open, the main activities room would then be used to ensure residents from both these areas had access to an adequate social engagement space.

On the morning of the inspection, many of the residents were arriving to the day rooms and one resident, who stated that they were always up early, had been assisted by staff to set up a painting station as they enjoyed art and appeared content doing this. Other residents were seen to be going out with relatives, one resident was going on a weekly shopping trip to a nearby shopping centre. Both the weekly and daily activities programme were clearly displayed in the centre, and included activities such as music, exercise programmes and arts and crafts.

The inspector saw that residents were offered refreshments and snacks mid morning and during the day. Residents who spoke with inspectors were satisfied with the choices available at meal times and reported portion sizes to be generous and appetising.

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

Capacity and capability

Overall, findings of this inspection were that Heather House Community Nursing Unit was a well managed centre, where residents were in receipt of a good standard of care. Management and staff were striving to ensure residents were provided with person centred care and support and some improvements in compliance were evident since the last inspection of August 2025. However, some further actions were required pertaining to care planning, fire precautions, premises, notifications of incidents and records. These will be further detailed under the relevant regulations of this report. Also, the provider was in breach of a condition of registration, requiring them to submit information to nominate a person participating in management. The provider had also applied to vary two conditions of the centres registration and this inspection would inform the decision making process for these applications.

This was an unannounced inspection carried out over one day by two inspectors to monitor the provider's compliance with the Health Act 2007(Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013(as amended).

Heather House Community Nursing Unit is a residential care setting operated by the Health Services Executive (HSE). The centre is currently registered to accommodate 60 residents. The registered provider of the centre is the Health Service Executive(HSE). There was a clearly defined management structure in place.

The interim person in charge was supported by an assistant director of nursing and three clinical nurse managers who had been appointed recently to the centre. There was also clinical nurse managers (CNM3) who covered the night duty management requirements in the unit. Nurses, healthcare assistants, catering, administration and maintenance staff also supported the person in charge. However, the senior managers with responsibility, authority and accountability for the service, outlined in the centres statement of purpose, were not named as persons participating in management on the centre's registration at the time of this inspection. This is actioned under Regulation 23: Governance and Management.

The centre had sufficient resources to ensure effective delivery of care and support to residents and the centre had a stable team of staff. This ensured that residents benefited from continuity of care from staff who knew their individual needs and preferences.

There was a good system of oversight of the quality and safety of care delivered to residents through a programme of audits and there was clear evidence of learning and improvements. Since the last inspection, the provider had reviewed and improved the centres menu with the addition of choices for each course offered to the residents during the day and large menu boards were displayed in each of the dining rooms. Whilst overall good practices were observed, the inspectors found improvements were required regarding management oversight of the tea time meal in Poppy unit. Residents were observed to receive their tea time meal at different times to their peers seated next to them in some cases and some residents meals were placed on the table ahead of them arriving to the dining room. Mealtimes in Lily unit were observed and the residents meals were served to all residents at the same time and these residents were seen to have a more sociable experience. This observed disparity between units meant that all residents had a sociable dining experience. This will be detailed under Regulation 23: Governance and Management.

Based on a review of the centres incident log, one incident that was reported as a complaint was not reported to the Office of the Chief Inspector as required under the regulations as it was not perceived as an allegation of abuse. This is actioned under Regulation 31: Notifications of incidents.

Documents requested were available to the inspectors throughout the inspection. A sample of staff files were reviewed and did not detail the required information as set out in schedule 2 of the regulations. This is actioned under Regulation 21: Records.

The complaint folder for the centre was also reviewed. The centre had their complaints policy and procedures in place to support residents and families to make

complaints if they wished to do so. However, on a review of complaints made, action was required to ensure that the provider was implementing their own complaints procedure in full. This is actioned under Regulation 34: Complaints.

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

The registered provider had applied to vary two of the centres registration conditions. The appropriate fees were paid and the necessary documentation had been submitted. The application reflected changes to condition one, the registered footprint of the centre, and changes to condition three, the number of beds the centre will be registered to accommodate.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was adequate having regard to the assessed needs of residents and the size and layout of the centre. The skill mix on duty was appropriate, and registered nurses were on duty over the 24 hour period with clinical nurse managers overseeing each unit daily.

Judgment: Compliant

Regulation 21: Records

Records set out in Schedules 2, 3 and 4 were available for review in the centre. A review of staff files showed that action was required to ensure that all information required in Schedule 2 was up to date. This is a repeat finding. For example:

- One staff record did not have a copy of the staff members CV on file for review.
- One staff file reviewed had unexplained gaps in their employment history.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not complied with the restrictive condition placed on the centres registration. This condition stated that "the registered provider shall, by the 22th January 2026, submit to the Chief Inspector the information and documentation set out in Schedule 2 of the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 as amended, in relation to any person who participates or will participate in the management of the designated centre".

Management systems required strengthening to ensure the service is effectively monitored. The oversight of the dining experience for some residents in the centre required attention, as some residents were not experiencing an organised dining experience.

Oversight of recruitment was seen to have some gaps, as two staff files reviewed did not contain the necessary information set out in Schedule 2 of the regulations. This is a repeat finding and is actioned under Regulation 21: Records.

A review of the centres complaints log, showed that the appropriate notifications were not submitted to the Chief Inspector as per Schedule 4 of the regulations.

The systems in place for oversight of maintenance were not fully effective to ensure deficits were actioned in a timely manner; for example the sliding door to a staff toilet was damaged, which was reported to maintenance four weeks prior to the inspection, had not been addressed. This was subsequently addressed during the inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed and has the necessary information required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of the centres complaints log, showed that the appropriate notifications were not submitted to the Chief Inspector as per Schedule 4 of the regulations. This is a repeat finding from the previous inspection. For example:

- Two reported altercations between a staff member and resident were not identified or reported as a safeguarding concern and therefore the associated NF06 was not submitted.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure complaints were recorded and managed in accordance with specified regulatory requirements, as follows:

- In one complaint record, the records did not demonstrate that the provider had implemented their complaints procedure in full.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Generally the policies in the centre were well maintained and contained up to date information. However, the policy regarding creation of, access to, retention of, maintenance of and destruction of records was out of date and required to be updated.

Judgment: Substantially compliant

Quality and safety

The inspectors found that overall, the residents living in Heather House Community Nursing Unit experienced a good quality of life in the centre, and that their health and social care needs were being met by the registered provider.

There were arrangements in place to assess residents' health and social care needs upon their admission to the centre, using validated assessment tools. Improvements had been noted since the previous inspection, however, further action was required to ensure that care plans and assessments are reviewed and updated when there is a change in a residents condition. This is actioned under Regulation 5: Individual assessment and care plan.

Residents had timely access to a general practitioner (GP) and residents who were identified as requiring additional health and social care professional expertise were referred and evidence of referral and consultation advice were evident in the residents care plan.

There was an activity schedule in place, which ensured that residents were provided with opportunities for social engagement and to participate in activities that were aligned to their capacities and capabilities. An external company was onsite Monday to Friday and a named staff member was allocated to activities at the weekends. Activities was based on both floors and staff ensured that residents could participate in group sessions as well as one to one activities, in line with their preferences. On the day of the inspection, a number of residents were observed to be encouraged and supported to partake in the activities that were taking place. Resident meeting minutes were reviewed and were seen to support residents to voice any concern and make suggestions which were then addressed by the management team.

Residents were facilitated to have access to supports such as the Irish Wheelchair association, Irish Disability Association and Headway(brain injury services) to promote their independence; residents who were identified by these services had access to external day services and access to person assistants (PA) to support their independence and enhance their quality of life.

On the day of the inspection, a number of residents had fallen ill on the evening before and two residents were in hospital with Influenza. The provider had acted appropriately and without delay in relation to implementation of their outbreak management plan. Staff had adequate supplies of personal protective equipment (PPE) and had isolation precautions in place where required.

The inspectors observed mostly good fire safety management systems. Building services and fire safety systems were being appropriately maintained at the recommended frequency. Some action was required to manage the risk of fire and to ensure adequate fire precautions were in place, in particular the management of day-to-day risks and maintenance of fire doors.

Overall the premises were well maintained and met the needs of the residents, however the inspectors observed areas of wear and tear which was impacting the resident areas, for example plasterboard walls were being damaged from pedal bins and trolleys. To address an issue previously raised regarding ventilation to the hairdresser room, the provider had arranged for a mechanical ventilation solution; this was being carried out at the time of inspection.

Regulation 17: Premises

Action was required to meet the requirements of the Regulation 17 and Schedule 6. For example:

- The water temperature in the domestic sink in the Occupational therapy room was scalding hot and required regulation to reduce the risk that a resident would acquire a burn injury.
- There was evidence that the first floor terrace was being used as a smoking area, without appropriate safety equipment
- The powered door control button leading from the outdoor terrace back into the Poppy day room was not working. The latch on the door to the corridor was damaged
- A sliding door into a staff bathroom was broken and required attention to ensure it could move into the locked position easily
- The day room had a retractable folding partition and this was not secured when opened, resulting in panels hanging loose. This was a risk where a resident may lean on it for support and was not included in the risk register
- The sinks in residents' en suites did not have a means to retain water in the sink if a resident wished to use this for personal hygiene
- In addition to general wear and tear, there were areas of plasterboard which were damaged resulting in exposed plaster

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Daily menus were displayed in suitable formats and in appropriate locations so that residents knew what choices were available at mealtimes. Residents that required assistance were assisted discretely and respectfully with their meals. Residents were monitored for weight loss and had access to dietetic and speech and language services where required.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

All relevant information was provided to the receiving facility when a resident was transferred out from the designated Centre. On transfer back to Heather house, information received from the acute facilities were reviewed and updated changes were reflected in the residents care plan.

Judgment: Compliant

Regulation 27: Infection control

Guidance in relation to Infection prevention and control and outbreak management was followed and implemented in a timely manner in the centre when resident's displayed acute respiratory symptoms. The provider had implemented their outbreak management plan which staff were familiar with to ensure the risk of transmission of Influenza to other residents and staff was reduced. A staff member in the centre was the designated infection prevention and control lead who worked with staff to ensure all guidance is adhered to and is a clinical adviser to staff onsite. Staff were knowledgeable in relation to isolation precautions and viral testing procedures.

Judgment: Compliant

Regulation 28: Fire precautions

Action was required to manage the risk of fire and to ensure adequate precautions were in place evidenced by the following findings:

- The inspectors observed gaps that had formed in some fire doors. There was a fire door audit in October 2025, however the findings of the audit had not been actioned, nor was there a date by when they would be addressed. This was a six monthly audit, which would be due within the following two months.
- there was a cushion on the seating in the smoking area, which did not have a label to indicate if it was fire retardant or not. This was removed during the inspection
- nurse stations were open plan to the corridors; while this is a reasonable arrangement, the risk associated with electrical equipment such as printers and shredding machines was not risk assessed
- an oxygen cylinder was being stored on the emergency trolley which resulted in the cylinder being stored against a radiator; oxygen cylinders should not be stored against sources of heat
- The evacuation floor plans at first floor did not accurately reflect the layout of the building; there was a cross corridor shown on the plans which were in a different location. This was not a fire compartment boundary, however staff incorrectly identified it as such to the inspector.
- There was no recent simulated drill to show that staff understood the strategy of how to assist residents down the stairs if required in the event that the dedicated evacuation lift was not available
- a small number of staff were overdue their fire safety training; these staff were scheduled for next training session within a short time frame

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure that care plans were up to date to reflect the changing needs of the residents in the centre. For example:

- A resident with a pressure ulcer detected in January 2026 did not have a wound assessment completed.
- One resident who had a high MUST(malnutrition assessment tool) score previously, had a new MUST score which denoted the score was now normal. This information was not updated to the residents care plan to update the change in the residents status.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to their General Practitioner(GP). There was good standards of evidence based healthcare provided in this centre. Allied health professionals also supported the residents on site when required for example, physiotherapy, speech and language and dietetics. The inspector saw evidence of ongoing referral and review as appropriate. On the day of the inspection, a number of cases of Influenza A had been detected and staff were knowledgeable of the guidance and residents were tested to determine if they had a viral infection and isolated appropriately to decrease risk of ongoing transmission to other residents and staff.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had access to a variety of activities on a daily basis. An external activities company was on site five days a week and a member of staff was rostered to facilitate activities during weekends. Resident meetings were held every three months and evidence of resident input and participation in the organisation of the centre in relation to activities, menus and choices for example was available on the day of the inspection.via resident satisfaction surveys and minutes of these meetings.

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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Heather House Community Nursing Unit OSV-0000714

Inspection ID: MON-0049393

Date of inspection: 17/02/2026

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 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records: The two identified files that were previously incomplete have now been fully completed and are compliant with the regulatory requirements. A staff file checklist has been developed and will be implemented to ensure that all required documentation is present and up to date for each employee. This checklist is now used consistently when reviewing staff records. In addition, administrative staff have established a system of ongoing review, whereby all staff files are audited every four months with an overall review completed by the ADON. This ensures continuous compliance, early identification of any gaps, and timely corrective action.</p>	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management: The Statement of Purpose (SOP) has been reviewed and amended to reflect all changes in line with the conditions outlined in the registration documentation in relation to management in Heather House CNU. This ensures that governance arrangements are accurate, current and aligned with regulatory requirements. The matter of the PPIM has been addressed. With regard to the dining experience, ongoing monitoring and review are in place under the supervision of the CNM2. A dining room audit was completed in February 2026, and a comprehensive Food and Nutrition Audit is scheduled for April 2026. All residents are actively encouraged to attend the dining room, and a social model of dining has been</p>	

reinforced among staff to enhance the mealtime experience. Residents' individual preferences are documented and reflected in their care plans to support person-centered care.

In relation to records management, this has been addressed under Regulation 21, where systems have been strengthened to ensure compliance. A staff file checklist has been developed and will be implemented to ensure that all required documentation is present and up to date for each employee. This checklist is now used consistently when reviewing staff records.

A robust system is in place for the management of complaints. The complaints log is reviewed twice weekly by the ADON and DON. All incidents and complaints are monitored, reviewed, and addressed promptly to ensure continuous quality improvement and resident safety.

All outstanding maintenance issues have been addressed. A maintenance folder has been introduced to each unit, to log and track issues. CNM2s have oversight of all maintenance requests recorded on the digital system for logging faults/issues, ensuring timely follow-up and resolution. In addition, administrative staff monitor common areas to maintain a safe and well-maintained environment.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Where gaps were identified, retrospective notifications have now been completed in line with regulatory requirements.

A robust monitoring system has been implemented to ensure ongoing compliance. All incidents and complaints are now reviewed twice weekly by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) against statutory notification requirements. This ensures that any notifiable events are promptly identified and submitted within the required timeframes.

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Regulation 34: Complaints procedure	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

All complaints are now formally recorded in a dedicated complaints log, ensuring accurate documentation and traceability. The complaints log is reviewed on a weekly

basis by the DON to monitor trends, ensure timely responses, documentation of acknowledgment. An outcome letter is stored in the file to support quality improvement and ensure full adequate closure of all complaints.

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Regulation 4: Written policies and procedures

Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

All identified policies have now been reviewed and updated to ensure they are complete, accurate, and reflective of current practice and regulatory requirements. In addition, all policies outlined under Schedule 5 have been reviewed to ensure full compliance with the regulation.

A system has been established to ensure policies are reviewed regularly on a 6 monthly basis and within the required timeframes, supporting ongoing compliance and best practice.

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Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

All identified issues have been addressed or are in progress.

The Thermostatic Mixing Valve (TMV) in the identified hand wash sink was replaced on 02.04.2026 to ensure compliance with infection prevention and control standards.

An area where cigarette butts were identified has been reviewed and confirmed as a non-designated smoking area. As part of ongoing monitoring and risk management, a request has been made to install CCTV surveillance in this location, and quotations have been obtained. Staff have also been made aware of this issue through safety huddles to ensure increased vigilance.

Maintenance-related matters have been addressed under Regulation 23: Governance and Management, where systems for oversight and tracking have been strengthened.

The powered door control button leading from the outdoor terrace was repaired on 18.02.2026.

The sliding door was repaired on 18.02.2026.

The retractable folding partition was locked and is now secure.

The replacement of sink plugs is progressing, with works scheduled for completion by the end of the Q2, 2026.

Identified areas requiring repainting are currently in progress and are scheduled for

completion by the end of April 2026.

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Regulation 28: Fire precautions

Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A system of weekly fire safety checks has been introduced and is documented in the unit fire register. These checks include fire door inspections, fire extinguisher checks, verification of clear escape routes, and testing of emergency lighting.

The gaps identified in the fire doors were all addressed on 01.04.2026.

The cushion in the smoking area was removed on 17.02.2026.

A risk assessment was completed on 18.02.2026 in relation to electrical equipment, including desktop computers, printers, and shredders. Following this assessment, printers and shredders identified as potential fire risks have been removed from the relevant areas.

In addition, the inappropriate placement of oxygen cylinders near radiators was addressed. This has been highlighted to all staff nurses, and ongoing spot checks are being carried out to ensure compliance with safe storage practices.

The evacuation floor plans have been changed to the appropriate plans on 18.02.2026.

Simulated fire drills have been arranged and are scheduled for completion by the end of April 2026 to ensure staff preparedness and appropriate response in the event of a fire.

Fire training has been scheduled and is ongoing. One session was completed in March 2026, with a further session scheduled for April 2026. The importance of fire safety, including maintaining fire doors and safe practices, has been reinforced during all training sessions.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

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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:

An audit of care plans is ongoing with a review of all associated documentation, to ensure that all resident assessments and care plans are comprehensive, up to date, and reflective of individual needs and preferences. A system of ongoing review has been established, whereby care plans are reviewed by the CNM3 & CNM2 at a minimum of four-monthly intervals, or more frequently as required based on changes in residents' needs. Next review will be completed in April 2026.

Clinical Nurse Managers 3's (CNM3s) along with the DON and ADON will conduct spot checks on care plans based on the KPI's with an aim of 4 per week, to ensure compliance, identify any gaps, and support continuous improvement in person-centered care delivery.

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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	30/05/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	18/02/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and	Not Compliant	Orange	18/02/2026

	details responsibilities for all areas of care provision.			
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	18/02/2026
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	18/02/2026
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.	Substantially Compliant	Yellow	18/02/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures,	Substantially Compliant	Yellow	20/04/2026

	including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
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	20/04/2026
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.	Substantially Compliant	Yellow	20/04/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1)	Not Compliant	Orange	20/02/2026

	(a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
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.	Substantially Compliant	Yellow	20/02/2026
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	20/02/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care	Substantially Compliant	Yellow	02/03/2026

	plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
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