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:	Athlunkard House Nursing Home
Name of provider:	Athlunkard Nursing Home Ltd
Address of centre:	Athlunkard, Westbury, Clare
Type of inspection:	Unannounced
Date of inspection:	05 November 2025
Centre ID:	OSV-0000729
Fieldwork ID:	MON-0048696

About the designated centre

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

Athlunkard House is a modern purpose built two-storey purpose nursing home. It can accommodate up to 103 residents. It is located in a residential area in Co. Clare on the outskirts of Limerick city. It is situated close to many amenities including St. Nicholas church and a local shopping centre. Athlunkard house accommodates male and female residents over the age of 18 years for short term and long term care. It provides 24 hour nursing care and caters for older persons who require general nursing care, dementia care, physical and intellectual disabilities, palliative care, respite and post-operative care. Bedroom accommodation is provided on both floors in 89 single and seven twin bedrooms. All bedrooms have en suite bathroom facilities. There is a lift provided between floors. There is a variety of communal day spaces provided including a dining room, day room and visitors rooms provided on each floor. Residents also have access to two secure enclosed garden areas.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	92

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
Wednesday 5 November 2025	09:40hrs to 18:00hrs	Fiona Cawley	Lead
Tuesday 4 November 2025	09:40hrs to 18:00hrs	Rachel Seoighthe	Support
Tuesday 4 November 2025	09:40hrs to 18:00hrs	Sharon Kane	Support

What residents told us and what inspectors observed

Inspectors found that residents living in this centre were provided with a satisfactory standard of care and were well-supported to live a good quality of life. Staff were observed to be familiar with the needs of residents, and to deliver care and support in a respectful and calm manner.

Inspectors arrived at the centre mid-morning and were met by the person in charge. Following an introductory meeting, inspectors conducted a walk through the building, giving an opportunity to observe the care provided to residents, review the living environment, and to meet with residents and staff. A number of residents were having breakfast in the dining areas and bedrooms, while other residents were relaxing in communal areas. Other residents were observed being assisted and supported by staff with their personal care needs.

Athlunkard House Nursing Home is situated on the outskirts of Limerick city. The purpose built two-storey facility, which is registered to accommodate 103 residents, provides care for both male and female adults with a range of dependencies and needs. There were 92 residents living in the centre on the day of the inspection.

Residents' living and bedroom areas were located on both floors of the building which were serviced by accessible lifts. Bedroom accommodation comprised of single and twin-occupancy rooms, all of which had ensuite facilities. Bedrooms were of a suitable size to cater for the assessed needs of residents, taking into account their privacy and dignity. There was sufficient space available in bedrooms to store residents' personal belongings. Residents were supported to decorate their bedrooms with personal items of significance, such as ornaments and photographs.

There were a number of communal areas available to residents throughout the centre for rest and recreation, including lounges and dining rooms. There was an oratory available which provided residents with a quiet space. There was also sufficient space available for residents to meet with friends and relatives in private.

Residents had unrestricted access to safe, secure outdoor spaces. These areas included a variety of suitable garden furnishings and seasonal plants.

The centre was bright, spacious and laid out to meet the needs of residents. Call-bells were available in all areas and were answered in a timely manner. Corridors were wide, with appropriately placed handrails, and were maintained clear of items to allow residents with walking aids to mobilise safely around the centre.

While the centre was generally clean, tidy and well maintained, inspectors found that some areas of the centre were not cleaned to an appropriate standard. In addition, the sluice facilities available in the centre on the day, did not fully support

effective infection prevention and control. This is discussed further under Regulation 27: Infection control.

There was a sufficient number of storage areas available in the centre. However, inspectors observed that a number of these areas, which contained resident equipment and clinical supplies, were unlocked and accessible which could be a potential safety risk for residents. Other storage rooms that contained potentially flammable materials were locked and the keys were not easily accessible to staff. Inspectors also observed cleaning products and medication inappropriately stored in a residents' kitchen area.

While there was a sufficient number of toilets and shower facilities available to residents, the only bath in the centre was faulty and required replacement. This matter had been ongoing since April 2024, and there was no plan in place to replace the bath at the time of the inspection.

There was a designated smoking area which was adequate in size and well ventilated. There were measures in place to ensure residents' safety when using this facility, including access to suitable fire-fighting equipment.

Inspectors spent time observing staff and resident interaction in the various areas of the centre. There was a relaxed, convivial atmosphere in the centre and residents were seen to be content as they went about their daily lives. They were relaxed and familiar with one another and in their environment. It was evident that residents' choices and preferences in their daily routines were respected. Residents moved freely around the centre, and were observed to be socially engaged with each other and staff. Other residents were observed sitting quietly, relaxing and observing their surroundings. A small number of residents were observed enjoying quiet time in their bedrooms. Communal areas were appropriately supervised and those residents who chose to remain in their rooms were supported by staff. Staff who spoke with inspectors were knowledgeable about the residents and their needs. Staff were observed to be kind and respectful in their interactions with residents, and care was delivered in a relaxed manner. Inspectors observed that personal care needs were met to an appropriate standard, aligned to residents' needs and preferences.

Visitors were observed coming and going throughout the day. Inspectors spoke with a number of visitors who were satisfied with the care provided to their loved ones.

Residents' feedback provided an insight of their lived experience in the centre. Inspectors spoke with a number of residents throughout the day. Overall, residents were satisfied with life in the centre. One resident told inspectors that they enjoyed living in the centre, while another said that they liked living in the home but that they 'can feel lonely at times'. Residents said that they were well cared for by staff. One resident told inspectors that 'staff couldn't do enough for you, they're so kind and helpful' and another resident said that 'staff are so friendly, I never have a problem'. There were a number of residents who were unable to speak with inspectors and were therefore not able to give their views of the centre. However, these residents were observed to be comfortable in their environment.

There were opportunities for residents to engage in recreational activities of their choice and ability. There was a schedule of activities in place which included exercises, bingo and music. Residents were seen to engage in group activities throughout the day, including an exercise class. One resident told the inspector that they really enjoyed the games of bingo that were played in the centre. Staff were available to support residents and to facilitate residents to be as actively involved in activities as they wished.

A small number of residents told inspectors that they preferred to spend most of their day in the comfort of their bedroom and that staff popped in to see them regularly. They said that they would use the call bell should they require assistance and the bell was always answered by staff in a timely manner.

The centre provided residents with consistent access to adequate quantities and choices of food and drink, and residents were complimentary about the quality of food. Inspectors observed the lunch-time meal service. Tables were set neatly and residents were offered a choice of drinks and food. Staff worked hard to ensure that the dining experience was a pleasant occasion. However, inspectors observed that the atmosphere was not relaxed and that the layout of dining environment did not support an organised meal service on the day. While there was appropriate background music playing in the area the volume was very loud. Food delivery trolleys and food disposal trolleys were inappropriately stored in the dining room throughout the meal time.

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

Capacity and capability

This was an unannounced risk inspection carried out by inspectors of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also reviewed unsolicited information received by the Office of the Chief Inspector in relation to concerns about the management of the centre, in particular, the standard of clinical care provided to residents and access to appropriate healthcare. While this information was reviewed and found to be substantiated, inspectors found that the provider had undertaken an internal review of the issues raised and had completed some actions to improve clinical care provided to residents.

Inspectors also followed up on the action taken by the provider to address the non-compliant issues found on inspection in June 2025. The provider had addressed a number of the non-compliant issues found on the previous inspection. However, inspectors found that the actions taken were not sufficient to bring the centre into full compliance with the regulations as there were repeated findings of non-

compliance with Regulation 23: Governance and management, Regulation 31: Notification of incidents and Regulation 5: Individual assessment and care plan. Furthermore, fire precautions and infection control were found not to be in full compliance with the regulations.

The registered provider of this designated centre is Athlunkard Nursing Home Limited, a company comprised of four directors, one of whom represents the registered provider. The provider is part of the Emeis group, which has a number of other designated centres within Ireland.

There was an established organisational structure in the centre with clearly identified lines of responsibility and accountability. The clinical management team consisted of a person in charge supported by two assistant directors of nursing and three clinical nurse managers. There was a full complement of staff in place including nursing and care staff, activity, housekeeping, administration, maintenance and catering staff. Management support was provided by a regional director who visited the centre every two weeks.

This inspection found that there was evidence of some improvements in relation to management systems in the centre, for example, in the areas of supervision, complaints, protection, and residents' rights. However, while there were a number of management systems in place to monitor the quality and safety of the service, inspectors found that some of the oversight arrangements in place were ineffective. A number of clinical and environmental audits were completed, such as, reviews of care planning, falls management, complaints management, infection prevention and control and nutrition. Where areas for improvement were identified, inspectors found that action plans to address these issues were not consistently developed and completed. Therefore, the systems in place did not fully ensure that the service provided was safe, appropriate, consistent or effectively monitored.

The provider had taken some action in relation to non-compliances in records. However, inspectors found further evidence of poor oversight of records management. While the provider had undertaken an internal review of an adverse incident in the centre, and had completed some actions to improve clinical care provided to residents, some records reviewed were incomplete and did not give appropriate detail to guide care.

Staffing levels in the centre were found to be sufficient for the number of residents and for the size and layout of the centre. The team providing direct care to residents consisted of registered nurses and a team of healthcare assistants.

A review of staff training records evidenced that staff had completed relevant training to support the provision of safe care to residents. This included fire safety, manual handling, safeguarding, managing behaviour that is challenging, and infection prevention and control training.

There were arrangements in place to ensure staff were supervised by the clinical management team. In addition, the provider had introduced the allocation of two

senior healthcare assistants in a supernumerary capacity each day to guide and support care staff.

Policies and procedures, required by Schedule 5 of the regulations, to guide and support staff in the safe delivery of care, were available to all staff.

A centre-specific complaints policy detailed the process of raising a complaint or a concern. The complaints procedure was clearly displayed in the centre. A complaints log was maintained with a record of complaints received. A review of the complaints log found that complaints were recorded, acknowledged, investigated and the outcome communicated to the complainant.

An electronic record of all accidents and incidents involving residents that occurred in the centre was maintained. A review of records identified that not all required incidents, as specified by the regulations, were notified to the Chief Inspector. For example, a number of skin integrity issues in the centre.

Regulation 15: Staffing

The number and skill mix of staff was appropriate with regard to the needs of the residents, and the size and layout of the designated centre.

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.

Judgment: Compliant

Regulation 21: Records

Records of nursing care provided to residents were not accurately or appropriately maintained in line with the requirements of Schedule 3(4)(b). For example;

- While records relating to the governance and management of the centre were maintained, inspectors did not receive requested documentation in a timely manner
- Records relating to a resident who no longer resided in the centre were not available

- Records of food provided for residents were not sufficiently detailed to determine whether the residents' diet was satisfactory. For example, a sample of residents' records reviewed did not give any description of the quantity of food or fluids consumed, therefore the residents' exact food and fluid intake was not recorded. The records were in place as the residents were losing weight and monitoring of their intake was required to inform the best action to take.
- Repositioning records were unavailable for a resident who had sustained several pressure related injuries, as directed by the resident's care plan.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspection found that the management systems in place to ensure that the service provided was safe or consistently monitored were not effective. This was evidenced by;

- The risk management system in place was inadequate in relation to the quality and safety of the service. For example, risks relating to;
    - fire safety
    - infection control
    - safe storage
- Poor oversight of records management, particularly, nursing documentation in relation to care planning; the content of a number of resident care plans did not clearly describe the interventions required to ensure that residents received care based on their assessed needs.
- Repeated non-compliance in relation to care planning, record management and notification of incidents

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications regarding the incidence of pressures ulcers were not submitted to the Chief Inspector within the required time-frame.

This is a repeated non-compliance

Judgment: Not compliant

Regulation 34: Complaints procedure

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

Judgment: Compliant

Regulation 4: Written policies and procedures

Written policies and procedures to inform practice were available for review. There was a system in place to ensure that policies and procedures were reviewed and updated.

Judgment: Compliant

Quality and safety

Inspectors found that residents living in the centre were generally satisfied with the quality of the care they received, and reported feeling safe in the centre. Inspectors observed pleasant engagement between staff and residents throughout the inspection. Residents had access to health and social care services, and regular opportunities for social engagement. However, inspectors found that assessment and care planning, residents' rights, infection control, premises and fire precautions did not fully align with the requirements of the regulations.

Inspectors reviewed a sample of residents' care records. A pre-admission assessment was carried out by the person in charge or the director of nursing, to ensure the centre could meet the residents' needs. Records showed that nursing staff used validated tools to carry out assessments of residents' needs upon admission to the centre. These assessments included the risk of falls, malnutrition, assessment of cognition, and dependency levels. Overall, while some care plan records reviewed were detailed and person-centred, inspectors found that the standard of care planning was not consistent, and a number of care plans did not include sufficient up-to-date information in relation to residents' current needs. As a result, these care plans did not provide staff with adequate guidance and direction to provide safe and appropriate care for residents. For example, the care plans of a resident whose condition had significantly deteriorated did not provide sufficient detail to guide and direct staff in the additional nursing interventions required, to support their care needs.

Following an adverse incident in the centre, corrective action had been taken by the management team to ensure all residents receive have access to appropriate medical and health care and that a treatment plan, as outlined by the allied health professional team is in place. Records demonstrated that there were referral systems in place and residents had access to health and social care professionals, such as dietician services, physiotherapy and speech and language therapy, as required. Residents had access to medical assessments and treatment by a General Practitioner (GP).

Overall, the design and layout of the premises was suitable for its stated purpose and met residents' individual and collective needs. However, the storage arrangements were inadequate.

Infection prevention and control measures were in place and monitored by the management team. Overall, the premises was clean, however, several clinical hand hygiene sinks were not cleaned to a satisfactory standard. Furthermore, the arrangements in place for the decontamination of continence care equipment posed a risk of cross infection.

The centre employed three staff who were dedicated to the provision of resident activities. The programme of activities included music, art and games. Residents had access to local and national newspapers, televisions and radios in their bedrooms and in the communal areas. Information regarding advocacy services was available in the centre and discussed at residents' meetings. Residents were supported to access this service, if required. Residents were supported to practice their religious faiths. Residents' meetings were held regularly and records demonstrated that there was discussion around food, complaints and activities.

The provider had measures in place to safeguard residents from abuse. The provider acted as pension agent for 10 residents and pensions were paid into a separate resident bank account. Vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were in place for all staff. A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse.

Inspectors found that the registered provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished. Visitors were observed attending the centre on the day of inspection.

Regulation 11: Visits

Arrangements were in place to ensure there were no restrictions to residents' families and friends visiting them in the centre. Residents could meet their visitors in private outside of their bedrooms in the communal rooms available.

Judgment: Compliant

Regulation 12: Personal possessions

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 premises that did not align fully with the requirements of the regulations. For example,

- Lockable storage was unavailable in the ground floor kitchenette.
- Residents were unable to avail of a bath if they so wished as the only bath available in the centre was out of service since April 2024.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Following an adverse incident in the centre, the provider had reviewed the process for temporary discharge of residents to another facility. Inspectors reviewed documentation and found that when residents were transferred to hospital from the designated centre, relevant information was provided to the receiving hospital. Upon residents' return to the designated centre, staff ensured that all relevant clinical information was obtained from the discharging service or hospital. Copies of transfer documents were filed in the residents charts.

Judgment: Compliant

Regulation 27: Infection control

Some issues were identified which had the potential to impact the effectiveness of infection prevention and control within the centre and posed a risk of cross infection. This was evidenced by:

- A bedpan washer was not provided on the ground floor of the centre. This meant that staff were required to travel to the first floor of the centre, to decontaminate continence care equipment after every use. This increased the risk of environmental contamination and cross infection.
- The utensil drying track in the first floor sluice room was rusted, and there was no drip collection dray.
- Several clinical hand hygiene sinks were visibly unclean and hand drying facilities were not provided at every sink.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The systems in place to ensure that residents were protected from the risk of fire were inadequate, as evidenced by;

- Access to several storage rooms on the first floor was by a key which was not easily accessible to staff. This could pose a risk of a delay in responding to a fire emergency in that area.
- A number of doors were wedged open with items of furniture, by-passing the automatic door closures in place to ensure effective containment of smoke and fire in the event of an emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of resident files and found that individual assessment and care planning was not fully aligned with the requirements of Regulation 5. For example:

- A care plan, which had been developed for a resident who had a restrictive practice in place, was not informed by a comprehensive assessment of the residents safety needs.
- A skin integrity care plan for a resident with pressure related injuries was not informed by a comprehensive assessment of the resident pressure care needs.

Some residents' care plans were not reviewed in response to their changing needs. For example,

- A nutritional assessment completed for a resident indicated that they were at high risk of malnutrition. However, the resident's care plan was not updated

reflect this assessment, to direct staff regarding the interventions required to ensure the resident's nutritional needs were met.
- Up-to-date information was not recorded in a resident's care plan to effectively guide and direct the care of a resident with a history of multi-drug resistant organism (MDRO) colonisation. The clinical management team were unaware of the resident's treatment plan.

This is a repeated non-compliance

Judgment: Not compliant

Regulation 6: Health care

A review of a sample of residents' files found that residents' health care needs were regularly reviewed by their general practitioner (GP). Residents were referred to allied health care professionals including a physiotherapist, dietitian, and a speech and language therapist, as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The implementation of restrictive practices was informed by risk assessments, which were reviewed regularly.

There were systems in place to ensure that staff were appropriately trained to support residents with responsive behaviours. Residents who experienced responsive behaviours had appropriate assessments completed. These informed the development of person-centred care plans, that detailed the supports and interventions to be implemented by staff.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that measures were in place to protect residents from harm or suffering abuse, and to respond to allegations, disclosures and suspicions of abuse.

The provider had clear processes in place to protect residents' finances. The provider acted as a pension agent for 10 residents, and arrangements were in place to afford adequate protection and access to these finances.
Judgment: Compliant
Regulation 9: Residents' rights
The provider had ensured that residents' rights were respected and that they were supported to exercise choice and control in their daily lives.
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 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Athlunkard House Nursing Home OSV-0000729

Inspection ID: MON-0048696

Date of inspection: 04/11/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: From the 1st January 2026, a protocol has been put in place to ensure inspectors receive all requested documentation in a timely manner. This will be reviewed quarterly by the Regional team when completing regional audits. From 1st January 2026, a monthly check will be commenced by the PIC to ensure that our agreed policy of scanning all discharged or deceased residents records for retention and inspection is implemented. From the 12th January 2026, all staff have been re-educated at safety pause meetings in relation to the importance of correctly completing food charts. They must include quantity, portion size, percentage eaten, fluid volumes, and any refusals. Following a review of wound care including repositioning charts, a protocol reflecting agreed policy is now in place to ensure repositioning charts are implemented and completed as necessary- completed From the 1st January 2026, all of the above will be monitored by the ADON weekly and reviewed at monthly governance meetings by the regional team, to ensure compliance	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

By the 16th January 2026, a review and update of the risk register was completed to ensure all risks including fire safety, infection control and safe storage are identified, assessed, and that assigned actions are implemented.

From the 12th January 2026, the daily walkabout completed by the in-house management team will ensure all identified risks are identified and actioned in a timely fashion.

By the 31st January 2026, risk management and enhanced supervision training will be provided to all clinical staff and managers, including the PIC. This training will include hazard identification, incident reporting, communication and escalation and risk control measures.

A comprehensive review and update of all care plans was completed for all residents to ensure they clearly describe assessed needs and required interventions- complete

From 1st January 2026, the CNM will review a sample of care plans and nursing notes each day to ensure all care plans are to a high standard, reflective of assessed resident needs and that they guide staff in the delivery of care.

In house training will be completed by the 30th January 2026 by the Person in Charge to all clinical staff on the completion of care plans with a focus on ensuring these are person-centred and include clinical interventions as indicated by members of the MDT.

From 1st January 2026, all of the above will be reviewed with the Regional Director and RPR at monthly governance meeting to ensure actions address the repeated non-compliances. Should audits and review at governance indicate a need for additional actions to sustain improvement in care planning, this will be in place by 31st March 2026.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

Post inspection, the identified outstanding notification was submitted retrospectively- complete

By the 31st March 2026, training arising from a root-cause analysis completed to identify why notifications were not submitted on time will be completed by the regional team. This training will address staff knowledge gaps, clarity on processes and improving communication.

Regulation 17: Premises	Substantially Compliant

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

Lockable storage was added to the ground floor kitchenette. This was completed on

7th November 2025

By the 31st March 2026, a replacement bath will be installed.

Regulation 27: Infection control	Substantially Compliant

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

The bedpan washer for ground floor has been replaced. Completed 30th November 2025

Installation of new drying rack with drip tray was completed 15th November 2025.

A full review and deep clean of clinical sinks was completed. This included ensuring all areas have hand drying facilities. Completed 30th November 2025.

Regulation 28: Fire precautions	Substantially Compliant

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

All doors identified to be locked with a key and not easily accessible to staff, have had keypad lock attached. This reduces the risk of a delay in responding to a fire emergency. Completed 30th November 2025.

All obstructions from affected doors were removed on the day of inspection- completed

Rooms where it has been identified that residents wish to have their doors open have been fitted with a door hold open mechanism, which will release at the sound of the fire alarm- complete

All staff, during safety pause meetings, have been re-educated on the importance of fire-safety requirements, emphasising that fire doors must never be propped open- complete

From 1st January 2026, routine fire-door inspections are now in place to ensure compliance with fire safety. These checks will be subject to a robust review and oversight by the PIC daily and the regional team monthly.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

A comprehensive review and update of all care plans was completed for all residents to ensure they clearly describe assessed needs and required interventions- complete

From 1st January 2026, the CNM will review a sample of care plans and nursing notes each day to ensure all care plans are to a high standard, reflective of assessed resident needs and that they guide staff in the delivery of care.

By the 23rd January 2026 a comprehensive review of all residents' history of multi-drug resistant organism (MDRO), both active and colonised, will be completed by the ADON. Once completed, all care plans will be updated to ensure they correctly guide staff in the delivery of each resident's treatment plan.

In house training will be completed by the 30th January 2026 by the Person in Charge to all clinical staff on the completion of care plans with a focus on ensuring these are person-centred and include clinical interventions as indicated by members of the MDT.

From 1st January 2026, all of the above will be reviewed with the Regional Director and RPR at monthly governance meeting to ensure actions address the repeated non-compliances. Should audits and review at governance indicate a need for additional actions to sustain improvement in care planning, this will be in place by 31st March 2026.

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	31st March 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	31st January 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	Not Compliant	Orange	31st March 2026

	effectively monitored.			
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	31st January 2026
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30th November 2025
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.	Not Compliant	Orange	31st March 2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate	Substantially Compliant	Yellow	31st March 2026

	that resident's family.			