



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

## Issued by the Chief Inspector

Name of designated centre:	Carnew Nursing Home
Name of provider:	Genesis Healthcare Ltd
Address of centre:	Gorey Road, Carnew, Wicklow
Type of inspection:	Unannounced
Date of inspection:	03 March 2026
Centre ID:	OSV-0008471
Fieldwork ID:	MON-0048252

## About the designated centre

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

Carnew Nursing Home is a new 90 bed creatively designed, spilt-level building, built to a high specification. The centre has three units - Oak, Birch and Rowan. The centre had three twin en-suite rooms in Birch unit and the remaining 84 rooms are single en-suite. Each level has its own access to internal courtyards. The centre is located in the countryside, on the outskirts of Carnew village, situated approximately 16 kms from the town of Gorey Co. Wexford and 15 km from the town of Bunclody, Co. Wexford. Carnew Nursing Home delivers care to residents over the age of eighteen with varying and complex needs ranging from lower dependency individuals to maximum dependency requirements. The centre also cater for residents who require general care, including residents with dementia, physical disabilities, chronic physical illness, psychiatric illness, frail elderly, and those requiring palliative care.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	71
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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 3 March 2026	08:30hrs to 17:30hrs	Laurena Guinan	Lead
Tuesday 3 March 2026	08:30hrs to 17:30hrs	Sarah Armstrong	Support

## What residents told us and what inspectors observed

Residents living in Carnew Nursing Home gave positive feedback of their experience. They told inspectors that it was a comfortable, friendly place to live, and the staff were kind and attentive. The centre is purpose-built and spread over two floors. There was a large, welcoming reception area at the entrance that had armchairs, a fish tank and a coffee dock. Offices were located beside the reception, and two corridors on either side led to resident accommodation which surrounded a secure courtyard. Access to the lower ground floor was via stairs and lifts. This floor also had access to secure outdoor areas for residents who resided here, and there was access to outdoor areas for the residents on the lower ground floor. An appropriately equipped smoking area was available on each floor, and the outdoor areas were well maintained, with ample seating, even pathways and planting areas which made them safe and pleasant spaces for residents to use.

The residents' accommodation was divided into units, with the Birch and Oak units on the ground floor and the Rowan unit on the lower ground floor. The corridors were free of obstruction, and had handrails and numerous seating nooks so residents could move freely throughout the centre. The inspectors saw a number of residents' bedrooms and they were clean and tidy. One resident was particularly keen to show inspectors their bedroom as they had personalised it with their own belongings and they said they were very happy with it. There were a number of visitors' rooms located throughout the centre which gave residents a choice of places in which to receive their visitors.

Each unit had its' own communal rooms and dining rooms that were furnished with comfortable seating and decorated with residents' artwork and photos. Sluice rooms and pharmacy rooms were kept locked and clean. There were store rooms on each floor and while most were clean and tidy, the household store room and the comms room on the lower ground floor were seen to have a number of bags and boxes stored on the floor. A treatment room on this floor was also seen to be unclean and have items such as a mattress and surplus equipment stored in it, making it unsuitable for use by residents.

The inspectors saw breakfast and lunch being served and observed residents being assisted in a calm and respectful manner. Residents had a choice to dine in their rooms or in the dining rooms, and all meals were seen to be hot and of generous size. Residents spoken with said that they felt there was a good choice of food available, and they found the food to be tasty. A visitor said they often assisted their loved one with their lunch, and the staff were accommodating with personal preferences, or if the resident changed their mind.

Visitors were seen coming and going on the day of inspection and all those spoken with said they were made to feel welcome. Inspectors were told that staff treated residents 'like their own family'. One visitor said their loved one had 'improved so

much because they are always involved in activities'. There was a varied activities schedule for each unit, which included regular trips to local attractions. Residents told the inspectors that they enjoyed the variety on offer, and activities staff were heard telling residents what was planned for the day and giving them a choice whether to join in. The atmosphere throughout the centre was calm, with call-bells answered promptly, and staff attending to residents in a friendly and respectful manner.

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 impact on the quality and safety of the service being delivered.

## Capacity and capability

Overall, inspectors found that the oversight and management of processes did not always ensure the service provided to residents was effectively monitored. In particular, the training and supervision arrangements for staff working in the centre had not ensured that residents were safeguarded, and not all actions committed to as part of the compliance plan from the previous inspection had been completed. These findings are discussed further under Regulation 23: Governance and management.

The registered provider of Carnew Nursing Home is Genesis Healthcare Limited. There was a well-defined management structure in place. The person in charge reported to the Head of Operations and was supported in their role by an Assistant Director of Nursing (ADON), and a team of clinical nurse managers (CNM's), staff nurses and healthcare assistants. Housekeeping staff, activities co-ordinators, catering, administration and maintenance staff made up the remainder of the staffing complement in the centre.

On the day of inspection, there was a calm and unhurried atmosphere throughout the centre. The staffing levels were sufficient to ensure that residents' needs were met in a timely manner. Staff interactions with residents were seen to be respectful, and staff who spoke with inspectors demonstrated a good knowledge of the residents and their assessed needs.

Staff had access to the Health Act 2007 and inspectors observed the Health Act to be available in hard copy within the designated centre. Following a significant safeguarding incident in the centre, the investigation identified that staff required refresher training in the detection, prevention and appropriate responses to abuse. The training was set as a condition to be completed prior to staff returning to work following the conclusion of the investigation. However, inspectors did not see evidence that this training had been completed, and records relating to the disciplinary procedures were incomplete. The registered provider submitted documents following the inspection which will be discussed under Regulation 16:

Training and staff development. Inspectors reviewed the staff training matrix and found a number of gaps, where staff were not up-to-date with mandatory training. Inspectors also reviewed the schedule of upcoming training and found that the staff who were out-of-date with safeguarding training were not listed to attend the next scheduled training session.

While the sample of staff files reviewed by inspectors contained most of the information required by the regulations, disciplinary records for two staff members were not available on the day of inspection. This will be discussed under Regulation 21: Records.

The inspector reviewed a sample of residents' contracts for the provision of services. These contracts clearly described the service to be provided to residents and set out the fees associated with the provided service.

#### Registration Regulation 4: Application for registration or renewal of registration

The registered provider had submitted a complete application to renew the registration of the centre within the required time frame.

Judgment: Compliant

#### Regulation 14: Persons in charge

The registered provider had ensured that there was a person in charge employed full-time in the designated centre. The person in charge had the appropriate experience and qualifications required to fulfil the role in accordance with the regulations.

Judgment: Compliant

#### Regulation 16: Training and staff development

The person in charge had not always ensured that staff had access to appropriate training. For example:

- A review of training records showed that some staff were not up-to-date with mandatory training in line with the centre's own policy. Nine staff did not have up-to-date safeguarding training. This included five staff nurses, two healthcare assistants, one activities co-ordinator and one administrative staff.

Furthermore, these staff members were not prioritised to attend the next scheduled safeguarding training in the centre.

- Two staff were identified as requiring refresher safeguarding training following a safeguarding incident in the centre. Performance review records since January documented that this additional training was required. The staff members completed online training immediately following the inspection and were scheduled for additional face-to-face training later in the month.

The person in charge had not ensured that staff were appropriately supervised. This was evidenced by the following findings:

- The investigation completed following a safeguarding incident in the centre identified the need for enhanced supervision of two staff members. Records submitted following the investigation indicated that both staff members were supervised for a period of time, and there was evidence available demonstrating that one staff member successfully completed this period. However, there was no evidence provided in relation to the second staff member. In addition, no performance review had been completed for this staff member, despite their identified need for extended mentoring, and there was no clear reference to ongoing supervision requirements.

Judgment: Not compliant

### Regulation 21: Records

The inspector reviewed a sample of four staff files representing a range of staff roles. All staff had valid Garda Vetting in place which was obtained prior to staff commencing in their roles. Staff files were found to contain the majority of requirements as set out in Schedule 2 of the regulations, however, two of the four files reviewed did not include information required under Schedule 2 (7), as performance improvement plans for staff were unavailable for review by inspectors.

Judgment: Substantially compliant

### Regulation 23: Governance and management

While the management systems ensured that residents were safe, the systems in place had not always ensured that the service provided was effectively monitored. For example:

- Oversight systems in place to ensure that the findings from a safeguarding investigation were implemented were insufficient. This was evidenced by the lack of documentation evidencing that action had been taken to ensure staff

were competent in safeguarding residents from the risk of abuse, and the correct disciplinary processes had been followed.

- The oversight systems in place to support staff access to appropriate training had not ensured that staff refresher training was provided to staff in line with the time frames outlined in the provider's own policy.
- Not all actions committed to in the compliance plan from the previous inspection had been actioned which resulted in some repeat findings on this inspection. This included:
  - Implementation of an 'early warning signs' system and associated training for staff to ensure timely response to signs of clinical deterioration in residents had not been completed.
  - Implementation of a system for tracking the multi-drug resistant organisms (MDROs) status of residents living in the centre had not been completed.
- Inappropriate storage practices were seen on the day, including:
  - Items stored on the floor of the household stores which did not promote good infection prevention.
  - Items stored on the floor of the comms rooms which did not promote good fire prevention.
  - The storage of surplus items in the treatment room meant it was not suitable for use by residents.

Judgment: Not compliant

### Regulation 24: Contract for the provision of services

A sample of five residents contracts were reviewed by the inspector, including the contract for one resident who was recently admitted to the centre. All contracts reviewed were found to meet the requirements of the regulations.

Judgment: Compliant

### Regulation 31: Notification of incidents

Not all the notifications as required in the regulations had been submitted to the Chief Inspector. This included:

- One safeguarding incident.
- An allegation of misconduct by staff.

Judgment: Not compliant

## Quality and safety

Residents living in Carnew Nursing Home were seen to receive a good standard of care from staff who were familiar with their needs, however, gaps were seen in the documentation of care plans, the safeguarding of residents, and the administration of medications.

The inspectors reviewed a sample of residents' care plans and saw that assessments had been conducted and care plans developed within 48 hours of admission using validated assessment tools. These care plans were seen to be reviewed on a minimum of four monthly intervals. However, while they were reviewed, they weren't always updated and were seen to contain irrelevant and historic information. This will be discussed under Regulation 5: Individual assessment and care plan.

Residents who had pressure ulcers had access to a tissue viability nurse, and their recommendations were seen to be implemented in practice with good effect. Residents also had access to a general practitioner, speech and language therapist and a dietician. Where concerns about a resident's nutritional status was identified, they were referred to these allied health professionals for assessment.

Residents had communication needs detailed in their care plans, for example, where residents had cognitive impairment, the use of short sentences and simple language was advised. Staff were heard to speak to residents in a quiet manner, and used their knowledge of the resident to converse with them.

Use of restraint in the centre was done after a comprehensive assessment of the resident, and consent from the resident, or their family where appropriate, was obtained. The type of restraint in use was correctly documented in the resident's care plan. Staff had received training in responsive behaviour and displayed a good knowledge of the residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). They told the inspectors the triggers for these behaviours and the de-escalation measures to use to help the resident. Validated assessment charts were used to guide correct care and the use of medication. Staff were familiar with the procedure to follow when escalated behaviours or patterns of behaviour were observed. However, while staff showed a good understanding of how to manage responsive behaviours, sufficiently detailed information was not always contained in a resident's care plan to ensure staff had up to date knowledge to manage the behaviour that was challenging.

Residents told inspectors that they felt safe living in the centre, and that they felt staff would listen and respond to their concerns. However, recommendations for enhanced training and supervision of staff following an investigation into a safeguarding concern were not seen to have been implemented. This posed a risk

that residents were not being adequately safeguarded and will be discussed under Regulation 8: Safeguarding.

Each residential unit had its own pharmacy to store medication. These rooms were clean and tidy, and temperature records for the room and the medication fridge showed that they were maintained within the recommended ranges. Medication trolleys were secured to the wall. There was a robust system to ensure there was adequate stock of medication, and the pharmacy delivered to the centre on a daily basis. Staff reported that medication administered in the morning was often administered one and a half to two hours after the prescribed time, which is not in line with best practice. Residents on modified diet or who expressed a preference for crushed medication had this documented on their medication administration sheet. However, these residents had not been supplied with medication in a format most suitable for their needs. For example, capsules were opened and tablets were administered in crushed format when liquid or dispersible preparations of the medication was available. Staff on the units and the person in charge acknowledged that these practices did not promote the safe and recommended administration of medication, and committed to liaising with the pharmacy and general practitioner to improve systems.

### Regulation 10: Communication difficulties

Residents were facilitated to communicate freely, and care plans detailed communication needs.

Judgment: Compliant

### Regulation 29: Medicines and pharmaceutical services

Residents did not always have their medication administered in a safe manner, in line with the centre's own policy on medication management, and in line with best practice. This was evidenced by:

- Residents who had swallowing difficulties had tablets administered in crushed format and capsules opened, despite liquid or dispersible preparations of the medication being available.
- Residents were routinely administered medication up to two and a half hours after the prescribed time which did not promote the safe administration of medication.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and care plan

While care plans were reviewed on a four monthly basis, they were not always updated to reflect the residents' current care needs. This was evidenced by historic and irrelevant information documented in care plans, for example:

- Information on antibiotic courses that had completed months previously were documented on current care plans.
- A number of dietician or tissue viability nurse consultations and recommendations dating back months or years were documented on current care plans.

While staff displayed a good knowledge of residents' needs, care plans did not always have information to direct staff in how to manage a resident's behaviour. For example, a resident with significant responsive behaviours did not have potential triggers and recommended strategies to de-escalate the behaviour detailed in their care plan.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents were seen to be referred to allied health professionals in a timely manner, and their recommendations were seen to be implemented in practice.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

Staff displayed good knowledge and skills to respond to and manage behaviour that challenges. Restraint was used in accordance with national policy.

Judgment: Compliant

## Regulation 8: Protection

Recommendations following a safeguarding investigation had not been fully completed, this included staff training in relation to the detection and prevention of, and responses to, abuse.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
<b>Quality and safety</b>	
Regulation 10: Communication difficulties	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially 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	Substantially compliant

# Compliance Plan for Carnew Nursing Home OSV-0008471

Inspection ID: MON-0048252

Date of inspection: 03/03/2026

## 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 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The Person in Charge, supported by the ADON and administrative staff, has completed a review of training records and identified that 95% of staff are currently compliant with safeguarding training. The remaining staff are on leave and are scheduled to complete training prior to returning to duty. Face-to-face safeguarding training sessions are scheduled on 7th May and 15th May 2026 to achieve full compliance.</p> <p>All staff are trained in Adult Safeguarding prior to their commencing date. Staff identified following the safeguarding investigation have completed both online and face-to-face safeguarding training prior to returning to full duties.</p> <p>To strengthen oversight of training compliance, the provider is introducing Strandum HR, which will provide real-time monitoring of training status, automated alerts for expiries, and reporting functionality to support governance review.</p> <p>Training needs are identified through supervision, observation of practice, and review of incidents, ensuring that training is informed by staff performance and identified risks rather than solely by training schedules.</p> <p>A competency framework is in place. The ADON and Clinical Nurse Managers assess staff competence through observation of practice, supervision, and scenario-based discussion to ensure staff can demonstrate appropriate safeguarding knowledge and practice. Enhanced supervision arrangements are implemented for staff requiring additional support. Supervision is documented and reviewed to ensure staff demonstrate safe practice prior to resuming full duties.</p>	

Regulation 21: Records	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 21: Records:  The Person in Charge has reviewed all staff files and ensured that performance improvement plans for identified staff are now completed and retained in personnel records.</p> <p>A structured audit process is in place, with staff files reviewed monthly by the ADON and findings reviewed by the Person in Charge to ensure compliance with Schedule 2 requirements.</p> <p>Any gaps identified are recorded and addressed through the centre's action log to ensure records remain complete and available for inspection.</p> ]	
Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The registered provider has strengthened governance arrangements to ensure that the service is effectively monitored and that risks are identified and addressed in a timely manner.</p> <p>The service monitors performance across key areas including:</p> <ul style="list-style-type: none"> <li>• Training compliance (currently 95% safeguarding compliance, progressing to full compliance)</li> <li>• Medication administration practices, including timing of administration</li> <li>• Care plan quality through audit</li> <li>• Timeliness of statutory notifications</li> </ul> <p>These areas are reviewed regularly and trended to support early identification of risk. A structured audit programme is implemented across the following areas:</p> <ul style="list-style-type: none"> <li>• Care planning</li> <li>• Medication management</li> <li>• Training compliance</li> <li>• Infection prevention and control</li> <li>• Safeguarding</li> </ul> <p>Audits are completed on a weekly and monthly basis by the ADON and Clinical Nurse Managers and are reviewed by the Person in Charge. Findings are escalated through governance structures where required and tracked to completion.</p> <p>The INEWS system is implemented, all nurses are trained in its use, and it is in operation for residents as clinically indicated. Observations are completed in line with residents' needs and reviewed daily by the ADON and CNMs to ensure appropriate escalation.</p> <p>A system is in place to record and monitor MDRO status, which is reflected in care planning and communicated at handover. Infections and MDRO trends are reviewed at monthly clinical governance meetings, with areas for improvement identified and acted upon. An IPC link nurse has been assigned dedicated supernumerary time to support improvements in infection prevention and control.</p> <p>Daily walkarounds are undertaken by the ADON and Clinical Nurse Managers, with oversight by the Person in Charge, to ensure compliance with infection prevention,</p>	

storage, and fire safety standards. Environmental improvements, including additional storage solutions, have been implemented and are monitored to ensure sustained compliance.

Governance arrangements operate across centre, provider, and organisational levels to ensure effective oversight and assurance of compliance.

The Person in Charge chairs a weekly site governance meeting, attended by the ADON and senior staff. The Head of Operations attends these meetings either on-site or remotely on a weekly basis, and provides oversight and challenge in relation to:

- Audit findings and trends
- Incidents and safeguarding concerns
- Training compliance and staff competence
- Progress against action plans and previous compliance plans

In addition to weekly engagement, the Head of Operations completes a monthly formal oversight review, which includes verification of audit findings, review of key risk indicators, and confirmation that actions identified at site level have been implemented and are effective.

Findings from these reviews are escalated to the Registered Provider Representative, who provides assurance to the Board of Directors through structured reporting on:

- Compliance status
- Key risks and emerging trends
- Outcomes of governance reviews and audits

Sustained compliance is supported through:

- Re-audit cycles
- Use of action trackers (training, safeguarding, incidents)
- Ongoing review of performance trends
- Governance oversight at centre and provider level

Clear escalation pathways are in place. Issues are escalated where:

- Audit findings are repeated
- Compliance levels do not improve
- Incident trends indicate emerging risk

Escalated risks are reviewed at provider and organisational level to ensure timely intervention and allocation of resources where required.

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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:

The Person in Charge has reviewed all regulatory requirements and submitted outstanding notifications.

A process is in place whereby all incidents are reviewed on a daily basis by the Person in Charge and ADON to determine if notification is required. Incidents are also reviewed at handover to ensure that all notifiable events are identified.

Recent review of incident records demonstrates improvement, with notifications submitted within required timeframes.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:</p> <p>The Person in Charge and ADON have reviewed medication management practices. Residents with swallowing difficulties have had their medications reviewed by the GP and pharmacist to ensure that appropriate formulations are prescribed.</p> <p>Medication rounds have been reorganised by the ADON and Clinical Nurse Managers to support administration in line with prescribed times.</p> <p>Medication administration is monitored through the electronic medication management system, which provides reports on administration times and variances. These reports are reviewed weekly by the Person in Charge and ADON.</p> <p>Medication management remains on agenda of all nurses' meetings.</p> <p>Medication errors are analyzed as part of monthly clinical meetings. All medication errors are reviewed by CNM, ADON and PIC. On the job mentoring session is delivered to nurses involved in errors after each error as part of the reflection process and learning exercise.</p> <p>Medication practices are further supported through daily observation of medication rounds and review of medication records by nursing management.</p> ]	
Regulation 5: Individual assessment and care plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <p>Care plans are under review to ensure that they accurately reflect residents' current needs. Historical and outdated information is being removed.</p> <p>Behaviour support plans are being updated to include clear triggers and appropriate de-escalation strategies.</p> <p>Care plan quality is monitored through monthly audit, and care plans are updated following any change in resident condition or multidisciplinary review.</p> <p>On the job mentoring sessions are continuing with all nursing staff regarding the development and implementation of holistic, person-centred care plans, with onsite training scheduled for June 2026.</p> <p>Care Planning remains on agenda of all nurses meetings.</p> <p>The ADON and Clinical Nurse Managers oversee care planning through regular review of documentation and observation of care delivery.</p> ]	

Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection: All recommendations arising from the safeguarding investigation have been implemented. Staff have completed required safeguarding training, and enhanced supervision arrangements are in place for those requiring additional support. Safeguarding practices are monitored through supervision, observation of practice, and review of incidents.</p> <p>The safeguarding committee meets quarterly to review all safeguarding incidents in the previous quarter and to identify areas for improvement and learning from the incidents. Safeguarding remains on the agenda for all staff meetings including Residents Forum. There are 2 Safeguarding designated officers in the center and all safeguarding incidents are responded to in line with policy.</p> <p>The Person in Charge ensures that all safeguarding concerns are investigated in line with policy and that learning from incidents is applied to practice.</p> <p>]</p>	

## 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	15/05/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	15/05/2026
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	31/05/2026
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	15/05/2026

	effectively monitored.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	15/05/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	01/05/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	15/05/2026
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection	Substantially Compliant	Yellow	31/05/2026

	and prevention of and responses to abuse.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	01/05/2026