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:	Glebe House Nursing Home
Name of provider:	Cowper Care Centre DAC
Address of centre:	Kilternan Care Centre, Glebe Road, Kilternan, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	04 June 2024
Centre ID:	OSV-0000039
Fieldwork ID:	MON-0040026

About the designated centre

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

The centre is located on the outskirts of Dublin and is close to local amenities such as bus routes, local shops and close proximity to the M50. It is a purpose built single storey building that opened for business in 1994. The service provides general nursing and dementia care as long term care, respite or convalescence for residents with maximum, high, medium, and low needs. They are registered to offer 54 beds to male and female residents primarily over the age of 65. There is a mixture of single and twin en-suite bedrooms provided over four units. There is a hub in the middle of the centre with a seating area and dining space, and this is well used by the residents and their visitors. There are also other communal areas on each of the units, and one unit has been designed to provide accommodation for residents living with dementia. There is access to the gardens and internal courtyards from each unit.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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
Tuesday 4 June 2024	08:25hrs to 16:35hrs	Lisa Walsh	Lead
Tuesday 4 June 2024	08:25hrs to 16:35hrs	Aoife Byrne	Support

What residents told us and what inspectors observed

The overall feedback from the residents was that the centre was a lovely place to live with friendly and helpful staff. One resident described Glebe House Nursing Home as a "very nice place with very nice people". Throughout the day, the atmosphere in the centre was relaxed and calm. Overall, the inspectors observed that staff provided dignity and respect to residents they cared for. It was evident that the staff members knew the residents' needs and particular behaviours well. Residents spoken with were highly complementary of the staff with a resident describing staff as "gorgeous". Visitors spoken with also were happy with the care provided with one saying they were "thrilled with the centre".

On arrival to the centre the clinical nurse manager (CNM) was providing oversight to the centre in the absence of the person in charge (PIC) and the assistant director of nursing (ADON). The CNM was also providing clinical care. The inspectors toured the premises and when the CNM finished providing clincial care they had an opening meeting. The PIC arrived at the centre later that day.

Glebe House Nursing Home is located on the outskirts of Dublin in Kilternan. The centre is purpose built and set out over one floor and is divided into four wings, one which is a dementia specific unit. The centre is registered to accommodate 54 and provides long-term residential care, respite residential care and convalescence care services to adults over 18 years of age. Residents were accommodated in 39 single occupancy bedrooms, all of which are en-suite, five single occupancy and five twin occupancy bedrooms with shared toilet and shower facilities. There were four vacancies on the day of inspection.

The centre was pleasantly decorated. Residents were encouraged to personalise their bedrooms with personal belongings and photographs. Communal space consisted of a sitting room in wing 1, wing 2 and wing 4, a prayer/quiet room in wing 4 and a large sitting/dining room located in the heart of the centre. The majority of residents were observed to spend time in the large sitting/dining room throughout the day. This area was also where activities took place. Residents from wing 1, wing 2 and wing 4 could access this area freely. Resident from wing 3, the dementia specific wing, needed staff support to access this area. There was a secure garden and courtyards for residents to use which had plenty of seating and were nicely decorated with flowers, plants and bird feeders.

There was additional communal space in wing 3 for the residents which consisted of, a sitting room, a quiet room and a dining room. Residents also had access to a secure garden area which was well-maintained.

There was a programme of activities scheduled for residents which changed weekly. This was displayed on notice boards throughout the centre for residents to see. On the day of inspection, inspectors observed staff taking the time to enjoy activities with the residents, such as playing skittles, flower arranging and completing exercise

programmes with some residents on a one-to-one basis. It was a sunny afternoon and the residents were offered ice-cream cones to enjoy while they enjoyed entertainment in the communal area.

The inspectors observed mealtimes in both the large dining room and the dining room in the dementia wing. They were a relaxed and social occasion for residents, who sat together in small groups at the dining tables. Residents could also have their meals in their bedroom if they preferred. Inspectors observed that there was sufficient staff available to provide support to residents who required support at meal times. The inspectors observed staff sit with residents and provided discreet, resident centred care and support.

On the day of inspection, residents were offered two meal choices, fish or pork chop with vegetables for their dinner. Residents gave mixed feedback in relation to the food with some clearly expressing that they were not satisfied with the food in the centre. Two residents who had fish said this was "very overcooked". Residents spoken with also said that the meat served is sometimes hard to chew. Some residents also expressed dissatisfaction with meals at tea time and said they would like a lighter meal, however, this meal is often chips or something with pastry.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place, and how these arrangements impact on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, inspectors found that the management systems in place were not effective in ensuring the quality and safety of care provided to residents was safe and consistent. In particular, the systems in place with regard to oversight of staffing, training and staff development, notification of incidents, premises, individual assessment and care planning and protection.

This was an unannounced inspection to assess the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013. It was carried out over one day by two inspectors of social services.

Cowper Care Centre DAC is the registered provider. There was a clearly defined management structure with identified lines of accountability and responsibility. The person in charge worked full time in the centre and reported to the chief executive officer. The person in charge was supported in their role by an assistant director of nursing, a clinical nurse manager (CNM), a team of nurses, healthcare assistants, activity co-ordinators, domestic and catering staff.

Monthly operations meetings were in place between the chief executive officer and the person in charge, which also included other senior management who were part of the group where clinical and non-clinical matters were discussed. Within the centre the person in charge met with other heads of departments monthly. Inspectors were informed that monthly nurses and staff meetings took place facilitated by heads of the department, however, no records of these meetings were available for inspectors to review. There were records of a nurse meeting in May 2024 and December 2023 and a staff meeting in February 2024 which were facilitated by the person in charge.

There were insufficient staff resources on the day of inspection to meet the assessed needs of the residents. Staff rosters, for all staff in the centre, from the previous two weeks and the week of inspection were reviewed. On the day of inspection, there was a shortage in nursing staff due to staff vacancies and the clinical nurse manager (CNM) was also providing clinical care. However, the CNM was also providing oversight to the centre in the absence of the person in charge and the assistant director of nursing (ADON). In addition, the ADON was working part time when the registered provider had committed to one whole time equivalent ADON in their statement of purpose. There was also a vacant laundry staff position, however, there was a plan in place to cover this vacancy with an additional cleaning staff on duty scheduled in the laundry.

Following a review of records, significant gaps in mandatory training were identified, for example, fire safety training and safeguarding training which could impact on the safe delivery of care to residents. Records reviewed identified 22 staff who were out-of-date with their fire safety training. When reviewing a sample of the rosters and comparing this to staff who had out-of-date fire safety training there was some nights three of the overall five staff were not up-to-date with their fire safety training. This poses a risk to safe evacuation of residents when there is the least amount of staff available. The plan in place to manage this risk was insufficient. Due to the risk posed to residents the provider was asked to submit training dates, which were received. Gaps were also identified in safeguarding training with 13 staff out-of-date with their training.

The systems in place for the oversight of notifications was not always effective. Two notifiable incidents had occurred, however, the Chief Inspector had not received the appropriate notification.

Regulation 14: Persons in charge

The person in charge worked full time in the centre and had the relevant experience and qualifications to undertake this role. They were knowledgeable of their remit and responsibilities. The inspectors found that the person in charge knew the residents and was familiar with their needs.

Judgment: Compliant

Regulation 15: Staffing

A review was required of the number and skill mix of staff having regard to the needs of the residents and the size and layout of the designated centre to ensure effective delivery of care. The findings of this inspection were that:

- There were two staff nurse vacancies. On the day of inspection, due to these vacancies, the clinical nurse manager (CNM) was providing clinical care. However, they were also providing oversight to the centre in the absence of the person in charge and the assistant director of nursing.
- The assistant director of nursing (ADON) was working part-time when the registered provider had committed one whole-time-equivalent or full-time ADON.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Significant gaps in fire safety training were identified on inspection which could impact the safe delivery of care to residents. Following a review of records, 22 staff were out-of-date with their fire safety training with some staff training which had expired two years ago. Due to the risk posed to residents the provider was asked to submit training dates, which were received. Gaps were also identified in safeguarding training with 13 staff out-of-date with this training also.

Judgment: Not compliant

Regulation 21: Records

The registered provider had ensured that all records set out in Scheduled 2 were kept in the centre and available for review on inspection.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were not fully effective to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. For example:

- The management oversight of residents' individual care needs, assessments and care plans was not fully effective. This is further detailed under Regulation 5: Individual assessment and care plan.
- Oversight systems for the submission of notifications to the Chief Inspector required review. Not all incidents required to be notified to the Chief Inspector were notified. This is detailed in Regulation 31: Notifications of incident.
- Two incidents had occurred in the centre that had not been responded to appropriately by following the centre's safeguarding policy.
- Oversight of staff training and staff development was not effective and as a result examples were seen where staff practice was not in line with the centres policies.

A review was required to ensure that the registered provider had allocated sufficient resources for effective delivery of care.

Judgment: Not compliant

Regulation 31: Notification of incidents

During the inspection, the inspectors identified that two notifiable incidents had occurred. However, the Office of the Chief Inspector had not received the appropriate notifications. The person in charge submitted the required notifications retrospectively.

Judgment: Not compliant

Quality and safety

While the inspectors observed kind and compassionate staff treating the residents with dignity and respect, as described above, the management systems in place to ensure the service was safe and appropriate impacted on the quality of care being delivered to residents. The impact of this is described under the relevant regulations below, including assessment and care planning, protection and premises.

Residents' social and health care needs were assessed using validated tools, however, inspectors found that some care plans were not completed within 48 hours of the residents admission. Furthermore, some of the residents assessments and care plans were not always reviewed where necessary. Inspectors viewed documentation related to the use of restricted practices in the designated centre and

managing responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). Inspectors identified that behavioural support care plans required review. This is outlined further under Regulation 5: Individual assessment and care plan.

An up to date safeguarding policy was in place to guide staff in the event of a concern of abuse arising. Inspectors found that safeguarding training was provided to staff, however, 13 staff were out-of-date with this training. The oversight of safeguarding also required improvement. During the inspection, inspectors became aware of two safeguarding concerns which had not been recognised as such, meaning that no safeguarding care plans had been put in place for the residents. Additionally, these concerns had not been notified to the Chief Inspector.

There were systems in place to promote residents autonomy over access to their personal property and possessions. Residents had adequate space to store and maintain their personal possessions. Residents' clothes were laundered regularly and a new and improved system was in place to ensure residents clothing was returned to the correct resident and was not misplaced.

Overall, the premises was in a good state of repair and met the needs of residents. The centre was found to be warm and bright with a variety of communal areas observed in use by residents on the day of inspection. Inspectors noted that some areas of the centre were not maintained to the same standard as others. There was also some storage issues and ventilation required review.

Regulation 12: Personal possessions

Residents retained control over their clothes. They had adequate storage space in their bedrooms, including a lockable cupboard for personal possessions. Linen and clothes were laundered regularly and returned to the right resident.

Judgment: Compliant

Regulation 17: Premises

While the premises overall provided a pleasant environment for residents, the inspectors found that some areas of the premises required action by the provider. This was evidenced by:

- There was some areas of wear and tear in the centre. For example, the ceiling in the sluice room in wing 1 had staining and peeling paint. Additionally, some walls throughout the centre had small holes in them and paint missing from the walls.
- There were some storage issues within the centre. For example, two residents comfort chairs, two wheelchairs and a large weighing scales were stored in the sitting room in wing 2. The prayer room in wing 4 had a large filing cabinet which was used to store incontinence wear. The quiet room in wing 3 also had a large filing cabinet stored in the room.
- Ventilation also required a review. Inspectors identified a strong odour in an assisted bathroom in wing 3. Within this bathroom inspectors also observed broken equipment, for example a disconnected pipe and the assisted bath out-of-order since July 2022.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Inspectors reviewed residents' records and saw that, in general, where the resident was temporarily absent from a designated centre, relevant information about the resident was provided to the receiving hospital. Upon residents' return to the designated centre, the staff ensured that all relevant information was obtained from the discharging hospital.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Comprehensive assessments were always completed for residents on or before admission to the centre. However, care plans based on assessments were not always completed no later than 48 hours after the resident’s admission to the centre.

While care plan were seen to be person-centred, and reflect residents choices, assessments and care plans were not always revised where necessary. For example, a residents care plan noted they were prescribed medication as a PRN medication (medicines only taken when the need arises). However, following a review this medication was no longer to be used as a PRN and the residents care plan had not been updated to reflect this. Furthermore, a resident predisposed to episodes of responsive behaviours (how people living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or

physical environment) had several incidents. They had a care plan in place for their responsive behaviours, however, this was not reviewed or updated after the incidents that had occurred.

Inspectors found that the quality of care plans for residents who displayed responsive behaviours was inconsistent. Some care plans in place to guide staff when supporting residents who displayed responsive behaviours did not reflect an appropriate, detailed, individualised management plan to guide staff practice and ensure the residents safety.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Where restraint was used in the designated centre it was used in accordance with the national policy. Residents who displayed responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were supported in a manner that was not restrictive.

Judgment: Compliant

Regulation 8: Protection

While the management team had responded appropriately to some safeguarding incidents, and followed their policy, inspectors became aware of two safeguarding concerns which had not been recognised as such, meaning that no safeguarding care plans had been put in place for the residents to ensure they were protected from 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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Glebe House Nursing Home OSV-0000039

Inspection ID: MON-0040026

Date of inspection: 04/06/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Completion timeline: 1 August 2024 The two staff nurses' vacancies have been filled in March and April 2024. These staff will be rostered in August 2024 after passing certification and completing the Cowper Care induction programme. The Assistant Director of Nursing (ADON) re-commenced full-time position as of July 2024. The ADON will be normally working opposite the Person in Charge and rostered together twice a week to facilitate a sufficient management oversight and an ample opportunity for internal communication to maintain consistency. The PIC and the ADON will also take turn in taking a leave to ensure that one is present in the absence of the other. In addition, the Compliance, Quality and Safety Manager provides an additional oversight in incident management and compliance with quality improvement activities. The Head of Service – Care provides clinical and management support in the background.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Completion date: 15 July 2024 The Service Manager completed his Fire Trainer certificate in May 2024. All staff with overdue fire training completed refresher training.	

The thirteen staff that were identified to have an overdue safeguarding training completed a refresher training on 29/06/24. All staff now have an up to date Safeguarding training.

The PIC will be reviewing the training matrix on a monthly basis to ensure refresher training is scheduled a month before the expiration of a staff member's training or as needed. The Compliance, Quality, and Safety Manager will validate adherence to agreed compliance plans regularly.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Completion date: 22 June 2024

All mandatory assessments and care plans will be completed within 48 hours of admission to the nursing home. The PIC/manager on duty will examine and sign off the admission checklist to make sure that all applicable policies and procedures are followed. Any amendments to the resident's care plans will be shared with the resident, their families, and every member of the staff who is providing their day-to-day care on the same day.

The PIC will be reviewing the training matrix on a monthly basis to ensure compliance with the regulations.

The PIC with the rest of the in-house management team will screen and investigate all reported internal incidents and near missed on a daily basis to ensure that notifiable incidents are reported within the required timeframe. Affected service users will then be assessed and referred to the appropriate health practitioners within the day for intervention and implementation of preventive measures. The same will be reflected on the residents' care plan and communicated to all staff and residents' families or representatives to ensure consistency. A notification feature was also recently activated in the current risk and compliance software in use where a notification email is circulated to the in-house managers, the Compliance, Quality and Safety Manager, and the Head of Service - Care for all reported incidents in the system. This additional layer of risk management will ensure timely incident management. Lesson learnt and improvement measures arising from incident analysis will be shared with all staff members as per local internal communication processes.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Completion date: 4 June 2024

Incidents and near misses will be communicated to staff as part of daily handover. These will be reviewed by the managers on a daily basis to identify learnings and gaps to prevent future recurrences.

The PIC with the rest of the local management team will screen all incidents internally and ensure that notifiable incidents are reported in timely manner.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Completion date: 19 July 2024.

Storage area for the platform weighing scale has been allocated to hoist room in wing 2 to avoid risk of trip and fall for staff, service users, and visitors.

The source of the odour in Wing 3 is due to Hydrotherapy bath not being used. A resident meeting was conducted on 16/06/24 and all service users have agreed to remove this equipment as they don't want to use it anymore. This is scheduled to be removed by 19/07/24.

HSE incontinence Team has been contacted post inspection to reduce the number of stocks delivery of incontinence wear in the care centre. Current excess of incontinence pads has been donated to different residential care facilities within the area.

Small holes and peeling paint on the ceiling were fixed and covered.

Specialised comfort chairs has been moved to storage unit and awaiting collection by HSE.

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: Completion date: 27 June 2024. All mandatory assessments and care plans will be completed within 48 hours of admission to the nursing home. The admission checklist will be reviewed and signed off by the PIC/manager on duty on the day of the resident admission/re-admission to the care facility to ensure that relevant policies and procedures are adhered to. The daily handover report form was also updated to capture updates or information regarding resident care. The PIC and the local management team are assigned a Wing/Unit to provide an oversight and conduct monthly review of resident assessments and care plans to ensure residents' records are reflective of their current condition and in line with the required timeframe. Changes made to the resident's care plan will be communicated to the resident, their families and all staff involve with the resident's care on the day.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: Completion date: 5 June 2024. All Incidents and near misses will be screened daily and notifiable incidents will be reported within the required timeframe. Safeguarding concern will be screened by the PIC to ensure compliance with the local and national policy. Relevant records will also be updated to reflect agreed safety measures and care needs.	

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/08/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	15/07/2024
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	19/07/2024

Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	22/06/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	04/06/2024
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (j) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 3 working days of its occurrence.	Not Compliant	Orange	04/06/2024
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	20/06/2024

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 that resident's family.	Substantially Compliant	Yellow	27/06/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	05/06/2024
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	05/06/2024