Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Peamount Healthcare Neurological Disability Service
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	19 March 2024
Centre ID:	OSV-0003505
Fieldwork ID:	MON-0042035

About the designated centre

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

The aim of Peamount Healthcare's Neurological Disability service is to promote the long term physical and psychological wellbeing of all residents through consultation, co-operation, collaboration and communication with them, their families or advocate and healthcare staff. The centre provides continuing care services for up to 19 residents, who have prolonged disorders of consciousness, complex medical needs associated with a neurological disability and require 24 hour nursing support. The centre is based in a large campus setting, situated in a rural area of County Dublin.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 19 March 2024	09:50hrs to 17:30hrs	Marie Byrne	Lead
Tuesday 19 March 2024	09:50hrs to 17:30hrs	Erin Clarke	Support

What residents told us and what inspectors observed

The findings of this unannounced risk-based inspection were that the provider had improved its levels of compliance across a number of regulations since the last inspection. The provider had taken a number of responsive steps to increase staffing numbers and to support a resident to transition from the centre in line with their assessed needs, wishes and preferences. However, improvements continued to be required in relation to resources and some aspects of the oversight and monitoring systems in the centre. These will be discussed in the body of the report below.

The designated centre is a large single-storey building on a large campus-based setting in County Dublin. There is also a number of medical, rehabilitation and residential services on this campus. The designated centre has 19 registered beds and there were 17 residents living in the centre at the time of the inspection. One resident was due for admission to the centre just after the inspection.

The premises was a large building which contained what staff referred to as "two wings". In one wing were eight resident bedrooms, which were clean, well-maintained and comfortable. The wing had a large bathroom, a shower room, a toilet, and a sluice room, all of which were well-equipped. Due to the care needs of residents, overhead hoists were installed in bedrooms and bathrooms. Other equipment, such as specialised hospital beds, were also used. The second wing, situated on the other side of the building, contained ten resident bedrooms. The wing also had two shower rooms, a bathroom, a staff room, and a physiotherapy room, which was equipped with all the necessary equipment for physical therapy. Overall, there were 18 resident bedrooms, with one double occupancy bedroom. In the centre of the building, near the entrance lobby, there was a large sunroom, which was used as a sitting room and was accessible from both wings. It also served as space for staff to complete handover duties from night to day-time staff.

Also, there was a separate visitors rooms, and an open-plan main lounge area, which also contained a partitioned area for dining and a small kitchen. Additionally, there was a linen room, a laundry room, a store room, a clinical room, and a staff office, all of which were located near the main lounge area.

Staff wore uniforms related to their role, for example, nursing staff, care support staff, and household staff. During the inspection, a number of staff referred to the designated centre as a "ward". The provider had identified that they required additional storage for large items such as wheelchairs, and this was identified as an action under their latest six-monthly review. Finally, there were raised desks in the corridor on each wing with computers and stools for staff to document residents' care and support.

The statement of purpose outlined that this centre providers support to residents diagnosed with neurological disabilities and/or prolonged disorder of consciousness following and acquired brain injury, spinal cord injury, and/or other complex medical

needs and illnesses that require 24-hour nursing support. Residents in the centre are assessed as high-maximum dependency, some of whom require specialist nursing input in the area of tracheotomy care, enteral feeding, epilepsy management, indwelling catheter care, bowel management, positioning and spasticity management. Medical cover is provided by a consultant in Neuro-rehabilitation. In addition, residents have access to a member of the medical team on the campus on a 24-hour basis. The centre is a member of the Hospice Friendly Hospitals forum and the community palliative care team are available, on referral. According to the provider's statement of purpose a number of health and social care professionals are available to support residents such as, advanced nurse practitioners, clinical nurse specialists, social work, pharmacist, occupational therapy, speech and language therapy, dietitian, and physiotherapy. Psychology and psychiatry input can be sought on a referral basis.

On arrival inspectors were shown around the designated centre by a nurse identified as shift leader in the absence of the person in charge. They were knowledgeable in relation to residents' care and support and were very helpful in showing inspectors around, introducing them to residents and staff, and supporting inspectors to access members of the management team and documentation in the centre.

Residents living in this centre communicated using various means of speech, facial expressions, and body language. Due to their complex support and communication needs, the majority of residents living in the centre required the support of staff who were very familiar with their support needs and preferences to support them. These staff members provided a range of services, including medical assistance, personal care, and emotional support to ensure that the residents were comfortable and safe.

The inspectors of social services had the opportunity to be briefly introduced to 16 residents living in the centre over the course of the inspection. The inspectors used several methods to evaluate the quality of care and support provided to the residents. They observed the interactions between residents and staff, engaged in discussions with both groups and reviewed documentation related to residents' care and support plans. Due to the complex support needs of the residents, residents faced difficulties in communicating their thoughts and opinions directly. However, the inspectors took into account the observations and discussions they had with the residents and staff, as well as feedback from families, to form judgments on the residents' lived experience of care and support at the centre.

One resident was taking part in a reflexology session, a number of residents were in bed relaxing or watching television and inspectors met one resident as they left with staff to attend a hospital appointment off-site. Inspectors met one resident in their bedroom and they smiled and shook hands with inspectors. When asked if they were happy, they gave inspectors a big smile and a thumbs up. They had posters of their favourite sports team in their room and a television to watch the games.

One resident was watching television in the sitting room and they told one inspector they were waiting to attend a physiotherapy appointment and were watching television until they had to leave. The inspectors later met them going for a

physiotherapy session. They were chatting away and appeared very happy to be going for physiotherapy.

Some residents' bedrooms contained a lot of medical equipment but every effort was being made to ensure their room was as homely as possible. They had pictures of themselves and the important people in their lives, and their favourite possessions on display. Some rooms had bright and colourful artwork on display, while other had poster and sports memorabilia.

Inspectors were informed by some staff that there was a limited number of staff who could drive the vehicles assigned to the centre and that this was sometimes impacting residents' ability to access activities in the community. For example, on the day of the inspection there were no drivers on duty and as a result residents were limited to campus or home-based activities. A resident who had a hospital appointment was supported by the patient transport services on the campus to attend their appointment via a hospital bed transfer.

Inspectors reviewed a sample of residents' activity records in the centre and found that opportunities for activities in the community were limited for some residents in line with their assessed needs, for some particularly relating to their health. For others there was some evidence of them accessing their community for shopping, going to local parks, going to restaurants and going to the cinema. Some home-based activities residents were regularly engaging in included, watching television, using their tablet computers, spending time with family and friends, or having aromatherapy or massage. Some residents were accessing the on-site wellness centre for parties or activities, and the on-site cafe. There was an alternative therapist on site during the inspection and they provided activities such as aromatherapy, massage and yoga for residents.

There were picture menus, picture rosters, and a community and activities board with pictures available for residents in the centre. Resident meetings are held monthly and discussions held include those relating to activities, menu planning, and the day-to-day running of the centre. Residents can choose to have weekly meetings with their keyworkers to plan activities and discuss aspects of their care and support.

Meals were produced on the campus by the capering department and choices are offered for each meal. A table-top oven is available in the centre for residents who wish to cook or bake. The provider's latest six-monthly review also refers to residents enjoying a take away in the centre with friends and family.

Staff spoke about the steps that were take to support a resident to successfully transition from this centre and spoke about how the resident continues to visit and attends weekly music sessions in the centre. Residents' views were captured as part of the providers latest six monthly review. Residents indicated they were happy living in the centre, and happy with how their bedrooms were decorated, their day-to-day routines, visiting arrangements in the centre, the availability of snacks and drinks and staff working in the centre. Both residents who spoke with the person completing the six-monthly review indicated they prefer to have familiar staff

working in the centre. This was also highlighted as a finding by the provider during the six-monthly review and they highlighted that residents "get on better" with familiar staff and would prefer to have little or no agency staff. The report highlights that residents reported a reduction in conversing with agency staff and that the number of incidents was higher with unfamiliar staff. Resident and residents' representatives feedback was again due to be captured as part of the provider's upcoming annual review of care and support in the centre.

There is information available in the centre to inform residents how to access independent advocacy services. There is a self-advocacy group on the campus which residents can choose to take part in. An annual residents' satisfaction survey is completed with residents and their representatives and they can access the support of the speech and language therapy or social work department or an advocate to complete these, if required.

In summary, residents in this centre presented with complex care, health and support needs. The provider had ensured that staffing levels and continuity of care and support had improved since the last inspection. Residents were supported to enjoy best possible health and were in receipt of a a good quality of care in the centre. Overall, the provider was self-identifying areas further improvements could be made including those to the premises, staffing, the ongoing recruitment of staff, and those relating to the documentation to demonstrate oversight and monitoring in the centre.

The next two sections of the report present the inspection findings in relation to the governance and management and how these arrangements affected the quality and safety of residents' care and support in the centre.

Capacity and capability

This unannounced inspection was carried out to follow up on a risk-based inspection that was conducted in October 2023. The initial inspection was prompted by unsolicited information received about staffing levels in the centre. The findings of the first inspection largely substantiated the contents of the unsolicited information. The centre was found to be non-compliant with Regulation 15: Staffing, Regulation 23: Governance and Management, and Regulation 5: Individualised Assessment and Personal Plan. At the time of the previous inspection, the provider was in active discussions with their funder due to the self-identification of the increase in residents' needs. It was explained to inspectors that the profile of new resident admissions to the centre had significantly changed over recent years. Consequently, it had become crucial to maintain a higher staff-to-resident ratio to ensure quality care and support to the residents. The centre's statement of purpose had been updated to reflect the changes in the profile of new resident admissions and increased staffing levels.

The findings of this inspection were that notable improvements have been made in

relation to staffing numbers, continuity of care and support for residents, the availability of planned and actual rosters, and the availability of Schedule 2 files for relief and agency staff. In addition, a resident successfully transitioned to a community-based designated centre operated by the provider that was in line with their assessed needs, wishes, and preferences. However, inspectors found that further improvements were still necessary, particularly in terms of resources, and oversight and monitoring in the centre.

The centre's management structure was clearly defined, with each staff member having specific roles and responsibilities. The person in charge was a clinical nurse manager 2 (CNM2), who worked full-time, five days a week, and was responsible for overseeing the centre's day-to-day operations. They were supported by a clinical nurse manager 1 (CNM1), a director of nursing and an assistant director of nursing (ADON). In addition to the CNM2 and CNM1, the centre also had access to several clinical nurse managers in grade 3 (CNM3) who worked as out-of-hours managers across the wider campus. They were available to residents and staff in this centre, ensuring clinical and managerial support at all times. The staff team supporting residents consisted of registered nurses, healthcare assistants, a social care leader and a social care worker, household staff and clerical staff.

The provider's latest six-monthly unannounced visit had taken place in January 2024 in line with regulatory requirements; however, it was not available in the centre on the day of the inspection; therefore, the findings and action plan were not available for review or action within the centre. The provider sent a copy of the report to inspectors following the inspection. This report highlighted areas of good practice in relation to restrictive practice reduction and staff training. It also highlighted that further improvements were required concerning the management of complaints and recruitment to fill staff vacancies. Furthermore, audits and reviews were carried out to evaluate the centre's operations. However, there was limited documentary evidence to demonstrate that the actions arising from these audits and reviews were implemented as planned. This suggested that the centre's monitoring and oversight arrangements may not be effectively addressing issues identified during its audits and reviews. Inspectors found that the centre was not fully resourced to meet residents' needs at the time of the inspection, and this will be discussed further under Regulation 23.

Regulation 15: Staffing

As per the centre's statement of purpose dated March 2024, the centre had a whole-time equivalent (WTE) of 40.74 staff. This staffing complement included 14 nursing staff, 21 health care assistants, one social care leader, and one activity staff. These numbers reflected an increase of three nurses and 5.5 healthcare assistants since the previous inspection. They also reflected the needs of one resident due to move into the centre from an acute setting that required additional supports.

The provider had submitted an application to their funder to increase the staffing

requirements and ensure the correct skill-mix in the centre. Part of this application included a centre visit by the funder to assess the requirements of residents. The provider had identified through their own audits and reviews of residents' care needs that the centre was not fully resourced in terms of staffing staff in order to to meet all residents' needs at all times and this is captured under Regulation 23. For example, residents who required one-to-one support or drivers to access many aspects of the community. At the time of this inspection the provider was continuing to liaise with the funder about the outcome of this staffing review. In the interim, they were providing additional staffing resources out-of-budget. There was now one additional staff nurse and one additional healthcare assistant on duty day and night in the centre.

Staff who spoke to the inspectors said that they felt very supported in their role and were able to raise concerns, if needed, to the person in charge. Staff also felt that improvements had been made since the previous inspection, and the increase in staff WTE had a positive impact for residents and made for a better work environment as there was a lesser requirement for external agency staff.

At the time of the inspection, there were 1.75 WTE nursing and four healthcare assistant vacancies. However, from a review of the staffing rosters and discussions with the person in charge and staff, the inspectors were satisfied with the arrangements in place to cover the required shifts. Improvements had been made to the continuity of relief and agency staff within the centre. Additional shifts to fill these vacancies were being completed by regular staff to ensure consistency of care to the residents. The person in charge informed the inspector that the provider was actively recruiting to fill any vacancies.

As previously mentioned, improvements were noted in relation to the availability and maintenance of planned and actual rosters and schedule 2 staff files in the centre.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures and staff were clear on their roles and responsibilities. The provider had systems to ensure oversight and monitoring of care and support for residents. However, these systems were not being fully utilised at the time of the inspection. For example, there was limited evidence to show that actions from audits and reviews were being followed up on, or completed. The provider was completing an annual and six-monthly review of care and support for residents; however, the latest six monthly was completed in January 2024 and not available in the centre on the day of the inspection.

Inspectors found that the centre was not fully resourced to meet residents' needs at the time of the inspection. Inspectors acknowledge that the provider was working with the funder to secure funding for additional staff, and improvements had been

made to continuity of care and support for residents. However, inspectors were informed that residents had limited access to some health and social care professionals such as social workers and dentists. A number of residents were due to have assessments completed by a clinical nurse specialist for behaviour due to an increase in incidents in 2023. One residents' assessment was in progress, and three residents were awaiting an assessment. There was 0.1 whole time equivalent social worker assigned to this centre, but this post was newly vacant at the time of the inspection. As a result some residents' medical cards had expired and inspectors were informed this had resulted in delays in areas such as accessing seating assessments for wheelchairs. Inspectors were informed this post was due to be filled in April 2024.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspectors reviewed the centre's statement of purpose. This is an important document that sets out information about the centre, including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. The statement of purpose in the centre required update, particularly relating to staffing numbers.

As requested during the inspection, an updated statement of purpose which contained the required information was submitted by the provider following the inspection. The inspectors found the information included was accurate and reflective of the whole-time equivalent hours of staff working in the centre and the residential service provided in the designated centre.

Judgment: Compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the centre and the Chief Inspector of Social Services was notified of the occurrence of incidents in line with the requirement of the regulations.

Judgment: Compliant

Quality and safety

Overall, while residents lived on a campus and this centre was designed and laid out in the style of a hospital ward, it was evident that residents were well cared for, in receipt of a good quality of care and supported to enjoy best possible health. It was a well run centre where residents were being kept safe and which was being operated in line with the provider's statement of purpose.

The provider was recognising that by improving some residents opportunities to access to activities they found meaningful in their community, would further contribute to their quality of life. Some residents were supported to engage in activities of their choosing in the centre, or on the campus. In line with their assessed needs, particularly those relating to their healthcare needs, some residents only took part in activities in the centre. A small number of residents were accessing activities in the local community.

Inspectors found that the provider and team in this centre were recognising that visiting plays a very important role in relation to residents' health and wellbeing. Inspectors found that residents were supported and encourage to spend time with their family and friends. There were a number of communal areas and a visitors room available if residents did not wish to receive visitors in their room. There were no restrictions in visitors unless this was requested by residents or not in the best interest of the residents safety.

The registered provider had systems in place for the assessment, management and ongoing review of risk including a system for responding to emergencies. The provider's risk management policy contained the information required by the regulations. The risk register and risk assessments were found to be reflective of the actual risks in the centre. Incidents were documented and incident trending was completed, at least quarterly.

The health and wellbeing of residents was supported through diet, nutrition and therapies. Residents had their healthcare needs assessed and care plans were developed and reviewed regularly. These plans were detailed in nature and contained information in relation to residents wishes and preferences. Residents had access to a consultant and other medical professionals. Residents were supported to access national screening programmes and had care plans relating to how they were supported to make a choice to access these. Residents were supported at time of illness and there were pathways to ensure they can access specialist palliative care. For the most part, residents were supported to access health and social care professional in line with their assessed needs. This access was limited for some residents and this was captured as a resource issue which was discussed under Regulation 23.

Regulation 11: Visits

The provider had a visitors policy in place and arrangements for visits was also detailed in the statement of purpose and residents' guide in the centre. Residents were being supported to contact their relatives by phone or video call and could

receive visitors if they wished to, and if it did not pose a risk. Inspectors were informed there was an open-door visiting policy on the centre and they observed visitors coming and going throughout the inspection. There were a number of private an communal spaces available for residents to meet with visitors, including a visitors room.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

As previously mentioned, a resident transitioned from the centre since the last inspection. The required supports were put in place to ensure their transition was successful and they were involved in decisions relating to their transition and discharge. Their discharge took place in a planned and safe manner.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the risk management polices, procedures and practices in the centre. The risk register was reflective of the presenting risks and incidents occurring in the centre. There were general and individual risk assessments which were reviewed regularly.

There were systems in place to record incidents, accidents and near misses and learning as a result of reviewing these was used to update the required risk assessments and shared with the staff team. There were systems to respond to emergencies and to ensure the vehicles in the centre were roadworthy and suitably equipped.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to enjoy best possible health. They had their healthcare needs assessed and had access to a number of doctors and a consultant on the campus. Those who required access to specialist consultants were supported to access these off-campus. They also had access to a range of health and social care professionals in line with their assessed needs such as speech and language therapists, dieticians, opticians, a tissue viability nurse, occupational therapists,

physiotherapists, clinical nurse specialist for older persons and a podiatrist. From a review of some residents' plans there was limited access to some services such as dental services which was not provided on site. A number of residents had not accessed a dentist in 2023 or in 2024 to date. Some residents also required the input of a social worker. This relates to resources and was discussed under Regulation 23.

Residents were in receipt of support at times of illness and at the end of their lives. Specific health action plans were developed and reviewed as required. These were detailed in nature and guiding staff practice. There was a care plan for each resident relating to accessing national screening programmes. Staff who spoke with inspectors were very familiar with residents' healthcare needs. Each resident was supported by a named nurse and keyworker.

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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 6: Health care	Compliant

Compliance Plan for Peamount Healthcare Neurological Disability Service OSV-0003505

Inspection ID: MON-0042035

Date of inspection: 19/03/2024

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant

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

Recruitment is ongoing to ensure vacant posts are filled. In the meantime, there is both relief and agency on a line to ensure consistency of care for the residents.

All statutory unannounced inspections are carried out by the registered provider within the required timeframes and all attempts are made to ensure these are processed through the correct channels for sign off in a timely fashion. The reports will be made available to residents and their representatives on request.

There is ongoing communication between PIC and ADON to review the needs of the area. Any concerns observed are escalated through risk assessment and added to the risk register. Control measures are added as appropriate. A new social worker began in post in April 2024. A meeting was scheduled between the Social Worker and St Brids key stakeholders on the 10th of April 2024 to discuss the needs of the area and highlight priorities such as medical cards.

Onsite oral hygiene training took place and was facilitated by SLT. All residents have an intimate care plan in place detailing their oral hygiene requirements. A review by the community dental service is available on a referral basis. Residents are supported to attend private dental practices if they wish.

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 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and	Substantially Compliant	Yellow	30/04/2024

	put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.	Substantially Compliant	Yellow	30/04/2024