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:	Cherryfield Housing with Care
Name of provider:	Fold Housing Association Ireland Company Limited by Guarantee
Address of centre:	2D Cherryfield Lawn, Hartstown, Clonsilla, Dublin 15
Type of inspection:	Unannounced
Date of inspection:	12 September 2024
Centre ID:	OSV-0000750
Fieldwork ID:	MON-0043541

About the designated centre

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

Cherryfield Housing with Care is a 56 bed centre providing residential care services to males and females over the age of 18 years. The service is designed to care for people with low to medium care needs. The centre is run by Fold Ireland, a not for profit organisation registered with Approved Housing Bodies of Ireland. The centre is a purpose built two-storey building. Each floor has its own dedicated entrance. The ground floor is a dementia specific unit. All bedrooms in the centre are single rooms containing en-suite shower and toilet facilities and a small kitchenette. Each floor has its own dining and sitting room areas and there are also several rest spots located in alcoves of the corridors with comfortable seating, books and magazines. A small computer station was also available for residents use. The centre is located approximately 10km north west of Dublin city centre. It has access to lots of local amenities including Blanchardstown shopping centre, restaurants, libraries, public parks and coffee shops. The centre is well serviced by local transport including a bus and rail service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	54

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
Thursday 12 September 2024	08:55hrs to 16:55hrs	Lisa Walsh	Lead

What residents told us and what inspectors observed

There was a friendly and welcoming atmosphere in the centre, and staff were observed to be helpful, kind, patient and respectful towards residents. The inspector met many of the residents during the inspection and spoke with seven residents in more detail. Feedback from residents was that they were happy living in Cherryfield Housing with Care. Residents were complimentary of the staff in the centre and the care they received, with one resident describing the centre as "very relaxed". Residents spoken with described staff as "lovely" and "very good". Several residents spoken with said at first they did not want to move into a designated centre, but now they feel it was the best decision they made. Staff and management were observed to be very familiar with the residents' needs.

Following the introductory meeting, the person in charge accompanied the inspector on a tour of the centre. Cherryfield Housing with Care is located in Hartstown, Dublin 15, close to a shopping centre, a park and public transport routes. The centre is set out over two level with stairs and lift access. The centre has 56 registered beds, which are set out over both floors. The ground floor accommodates up to 27 residents living with a diagnosis of dementia with low to medium dependency needs. The first floor accommodates up to 29 residents who have been assessed as having low dependency needs and are very independent. Residents on the first floor had their own access to the building and could freely come and go.

Residents were accommodated in single occupancy bedrooms with an en-suite and a kitchenette. Each resident's front door was numbered and brightly coloured. Residents on the ground floor had a memory box outside their front door with items of personal significance to help them identify their room.

Overall, the centre was nicely decorated, however, the inspector observed that some minor maintenance issues were required in areas. Communal space consisted of a large resident seating area on the ground floor which was overlooked by an atrium on the first floor, three small dining rooms and a smoking room on each floor. On the ground floor, there was also a smaller lounge area and a games room which had a pool table for residents to use.

Each corridor within the centre was named after different streets in Dublin and were decorated to give a homely atmosphere with plant pots on window ledges and artwork. On the first floor, there were alcoves with computers for residents to use and shelves full of books. There were also seating areas for residents to have a quieter space to relax in and over look the manicured courtyards. The secure courtyards on the ground floor were well-maintained, clean, tidy and pathways were free from debris allowing residents a safe space to walk in. There was a new smoking area in one of the courtyards with appropriate fire equipment such as a metal ash tray and fire blanket. Residents who smoke had a personal emergency call

bell to use if needing support. The courtyards were nicely decorated with hedges, tress, shrubs, flowers and garden features.

Residents were up and neatly dressed in the ground floor seating area. There was an activity programme in place with planned activities daily, each morning the same activity was provided. On the morning of the inspection, some residents and staff were watching gentle exercises on the television and following along. In the afternoon, music was playing on the television and residents were singing along. Residents spoken with on the first floor said they like to do their own activities, for example, they go out and meet with their family or friends. Others residents on the first floor said they like to stay in their own room to knit, read, listen to music. While visitors were highly complementary of the care and the staff, they gave mixed feedback about the activities on offer. Some said the residents enjoyed the activities available and others said that the activities needed to be improved upon. Resident meetings also reflected residents feedback that they would like more activities.

Each floor had three small dining rooms, which were nicely set with fresh flowers on the tables and gave a pleasant homely experience when residents were eating. Meals were prepared in the kitchen on the ground floor and brought to the dining rooms in a bain maire. Menus were available for residents to choose their meals from, with a visual menu available for residents who lived on the ground floor. Residents spoken with said they enjoyed the food and spoke about being able to have a glass of wine with their dinner, like they would at home. The inspector observed that the three dining rooms on the ground floor were locked between meals, restricting residents access to this communal space.

Residents were observed to be receiving visitors with no restrictions throughout the day. Visitors reported the same and said they could come to the centre "anytime". Visitors spoken with said their loved ones were very happy living in the centre. Visitors reflected the resident feedback about staff, saying staff were "very friendly and very kind" and "amazing".

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted 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

Residents expressed a high level of satisfaction regarding the care and support provided to them, however, the inspector found that improvements were required in some areas of the service to ensure the service was safe, consistent and of a good quality. In particular, the systems in place with regard to oversight of individual

assessment and care planning, managing behaviour that is challenging, residents rights, complaints, premises, statement of purpose and directory of residents.

This was an unannounced inspection conducted by one inspector of social services over one day to assess compliance with the regulations and review the registered provider's compliance plan from the previous inspection.

The registered provider for Cherryfield Housing with Care is Fold Housing Association Ireland Company Limited by Guarantee. There was an established governance and management structure in the designated centre, however, the lines of authority and accountability for a specific role was not known on the day of inspection. For example, when the inspector arrived at the centre, members of management did not know who was the responsible person while the person in charge was away from the centre on other duties in line with the statement of purpose.

The person in charge is responsible for the centre's day-to-day operations and reports to the director of care services, who in turn reports to the registered provider. The centre provides 24-hour care and support to older persons with low and medium-dependency needs and is staffed by care workers. The person in charge worked full time in the centre and was supported in their management of the centre by senior care workers, with two on duty on the day of inspection. The person in charge and senior care workers demonstrated a commitment to providing a good quality service for the residents. They were supported by a team of care workers, laundry, domestic and catering staff. The clinical nurse role was currently vacant and actively being recruited for. The clinical nurse's role was to provide clinical oversight of care planning and clinical expertise. During the time of the inspection, the person in charge received clinical support from an agency clinical nurse.

The systems of oversight were not robust, this was evidenced by:

- Lack of evidence that regular management meetings were held. The inspector was informed that the person in charge met regularly with the director of care services to discuss key worker monthly reports which were a review of each individual resident. However, there were no records available of the day of inspection of any management meetings to have taken place for 2024 for the inspector to review.
- A restraint committee was established, however, there was a record of only one meeting which took place in May 2024 with the person in charge and the director of care services.
- There was an audit schedule in place covering key areas such as, medication management, care plans and key worker reports. However, audits completed did not identify key areas of non-compliance identified on the day of inspection, for example, care plan audits and a complaint audit.
- Some actions from the previous compliance plan were completed, for example, fire blankets were now available in the courtyard and floor plans

had been updated to indicate escape routes. However, repeated non-compliance were found and is detailed under Regulation 17: Premises.

There was a complaint log in place which recorded all complaints made, however, improvements were also required in the management of complaints.

Regulation 19: Directory of residents

The registered provider had a directory of residents maintain, however, it did not contain all of the information set out in Schedule 3.

Judgment: Substantially 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 and required further oversight. This is detailed under Regulation 5: Individual assessment and care plan.
- The was a limited schedule of audits and this was a lost opportunity to improve outcomes for residents. What audits were carried out did not identify areas for improvement identified on this inspection.
- The oversight of restrictive practice was not sufficiently robust on the ground floor. A review of care plans for these residents found that the least restrictive measure was not evidenced. Furthermore, the practice of locking dining rooms outside of mealtimes required review and limited access to this communal space available for residents to use. Training was also required to ensure staff had up-to-date knowledge and skills to respond to and manage responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment).
- Deputising arrangements in place to provide cover while the person in charge was on other duties from the centre were not clear to ensure the continued leadership and oversight of the service. On arrival to the centre the person in charge was on other duties and the staff in the centre did not know who was the responsible person. One of the roles for deputising had been vacant from May 2024.
- A review of residents rights was required to ensure that residents had opportunities to participate in meaningful activities and that residents had the right to a smoke free environment, which is a repeat finding due to ventilation issues.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a written statement of purpose relating to the designated centre, which had been reviewed in February 2024. However, this required some amendments to meet the requirements of the regulation. For example:

- The centres registration details were not aligned with the information set out in the Certificate of Registration.
- The arrangements for dealing with complaints required review.
- The arrangements for management of the centre where the person in charge is absent required review due to a current vacancy.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Some improvements had been identified in the recording of complaints. Residents had made complaints which were recorded on the centres complaint log. However, for all complaints there were no written responses given to the complainant informing them whether or not the complaint was upheld, the reasons for that decision, any improvements recommended and details of the review process.

Judgment: Substantially compliant

Quality and safety

The inspector observed kind and compassionate staff treating the residents with dignity and respect. This inspection identified some areas where improvements were required to fully comply with the regulations.

The person in charge had arrangements for assessing residents before admission into the centre. Care plans were in place for all residents and were reviewed at regular intervals, not exceeding four months. Residents and their families were involved in care plan reviews. End-of-life care plans reviewed contained person-centred detail regarding residents' end-of-life care wishes and preferences and had clear information for staff to follow to ensure that care was provided according to

residents' wishes at this very important time. Notwithstanding this area of good practice, some gaps were observed concerning assessments and care plans, for example, some residents with specialist communication needs did not have a care plan in place.

An up-to-date restraint policy was in place and guided staff on best practice. 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) had care plans in place. However, these were not detailed enough to guide staff practice. In addition, the inspector observed the use of some restrictive practices which were not in accordance with the national restraint policy, such as, PRN (medicines only taken when the need arises) been given to a resident without any other alternatives trailed first.

The inspector saw that staff engaged with residents in a respectful and dignified way. Residents were observed to be reading newspapers, listening to the radio, watching television and have internet services communally and in their bedrooms. Residents were consulted with about their individual care needs and had access to independent advocacy if they wished. Two residents' meetings were held in 2024 with a good level of attendance by residents. There was an activity schedule in place. However, this required review to ensure that residents has access to meaningful activation.

Overall, the premises 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 and beautifully manicured courtyards. The inspector noted there were some storage issues which is included under regulation 17 premises.

Regulation 10: Communication difficulties

A resident whose first language was not English had a care plan in place to support their communication needs. However, two residents who had specialist communication requirements did not have a care plan in place.

Judgment: Substantially compliant

Regulation 13: End of life

In general, the centre does not accommodate residents who were approaching the end of their life. There was a policy in place to ensure residents end of life wishes were documented and individualised in their care plan. All residents had an end of

life care plan in place which detailed their religious and cultural needs and any arrangements they wished to have in place.

Judgment: Compliant

Regulation 17: Premises

The premises provided a pleasant environment for residents, however, the inspector found that some areas of the premises required action by the provider. For example:

- Ventilation in some areas required review. The inspector identified a strong odour of cigarettes when entering into the communal seating area on the ground floor, the atrium overlooking the ground floor and some corridors near the smoking room on the first floor, despite windows being open and an extractor fan being in operation. This is a repeat finding.
- There was some signs of wear and tear in the centre. For example, large cracks were observed on some walls and ceilings in the corridors of the centre and some communal rooms. Additionally, some areas of the centre had staining on the walls.
- There were some storage issues observed within the centre, for example, a cleaning chart was stored in a refuge area on the first floor.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

There were gaps noted in assessment and care plans. For example:

- A resident who had responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) had a care plan in place. However, this had not been reviewed as required following two recent incidents which had taken place.
- Assessments had been completed for all residents on the ground floor prior to the implementation of a restrictive practice. The person in charge confirmed that 25 of the 27 residents did not require the support of the restriction put in place, the assessments did not accurately reflect the residents care needs and required review.
- A resident whose communication needs had changed since their admission had not been assessed by an appropriate healthcare professional.
- There was no care plan in place for a resident who had reported a safeguarding concern.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Restraints were not always used in line with the national policy. For example:

- A residents ABC (antecedent, behaviour and consequence) chart recorded an incident which took place. The resident was given a PRN (medicines only taken when the need arises) without any other alternatives trailed first. This is not in line with national policy.
- The oversight and management of residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) required improvement. Residents who were prescribed and administered chemical restraint had a care plan in place. However, care plans did not detail options including a stepped approach to ensure that responsive behaviours were managed in a manner that is not restrictive.

On review of a sample of care plans for responsive behaviours, the inspector found that there was no record to indicate that less restrictive interventions had been trialled for all residents prior to implementation. Additionally, staff training was required to ensure that they had the skill and knowledge to respond to and manage responsive behaviours.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to protect residents from abuse. Residents who required additional one-to-one supervision had this support in place. Any incident or allegation of abuse had been investigated by the registered provider. Staff had received safeguarding training and were knowledgeable about what constitutes abuse and how to report suspected abuse in the centre. Residents reported that they felt safe in the centre.

The registered provider was a pension agent for residents. Records shown to the inspector confirmed residents' money was managed through a separate client account.

Judgment: Compliant

Regulation 9: Residents' rights

While residents rights were generally respected, based on feedback in a residents meeting, the inspector observations and visitor feedback, some areas for improvement were required. For example, there was an over reliance on the use of television for activation and there were lengthy periods of time where residents were observed sitting in the ground floor seating area without other meaningful activation. There was an activity programme available, however, the same activity was repeated every morning.

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 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cherryfield Housing with Care OSV-0000750

Inspection ID: MON-0043541

Date of inspection: 13/09/2024

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: Compliance with Regulation 19: Directory of Residents In accordance with Regulation 19, we have undertaken a comprehensive update of the Directory of Residents. This update includes verifying and ensuring the accuracy of all entries to align with the required standards. To maintain compliance, we will implement regular reviews of the directory moving forward. This proactive approach will help us ensure that our records remain accurate and accessible.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • We have secured a nurse who will commence employment with us in January 2024. • In the interim, we will continue to provide nursing coverage through an agency nurse who has been with us for the past few months. This agency nurse will remain in place until our new clinical nurse commences employment. Additionally, we have enhanced our management team by promoting one of our senior care workers to the position of a team leader. This promotion is aimed at providing additional support to the manager and strengthening our overall care delivery. Care plans have been reviewed and updated,	

We acknowledge that the limited schedule of audits has resulted in missed opportunities to identify areas for improvement in our services.

We recognise the importance of a thorough audit process in enhancing resident outcomes. To address this, we are committed to expanding our audit schedule and developing a more robust framework for evaluating our services. This will allow us to better identify areas for improvement and implement necessary changes to enhance the quality of care provided to our residents.

These staffing adjustments reflect our commitment to maintaining high standards of care and support for our residents.

• Restrictive Practice Care Plans: Our restrictive practice care plans have been thoroughly reviewed and updated to ensure they meet current standards.
• Dining Room Access: We have conducted a review of the dining room doors, and all residents now have access, with the exception of two residents who have appropriate assessments and care plans in place.
• Staff Training: All staff members have completed training on managing responsive behaviours, and dementia care. A refresher course on dementia training will be organised to further enhance our team's skills.
• Complaints Policy: We have updated our complaints policy to ensure clarity and effectiveness in addressing resident concerns. All verbal complaints will be responded to in writing.
• Management Support: Staff have been informed that, in the absence of the manager and the director, they can reach out to the CEO for support.
• Weekly managers meetings are documented

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
We have reviewed and updated our Statement of Purpose in accordance with Regulation 3.

The updated document now accurately reflects our services and complies with the relevant regulatory requirements. We are committed to ensuring that our practices align with the guidelines set forth.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A thorough review of the current complaints policy will be conducted to identify necessary updates, ensuring alignment with regulatory requirements. Verbal complaints will be responded to in writing.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
We have implemented care plans for two residents who have specialised communication requirements. These plans are tailored to meet their individual needs and ensure effective communication and support.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To address the issue of smoke odour in the smoking room, we have taken several steps to improve ventilation. We have installed a larger extractor fan to enhance air circulation and advised residents to keep the windows open during smoking times. Residents that like to smoke in the garden have been advised to keep the garden door closed These measures are part of our ongoing commitment to maintaining a pleasant environment for all residents.

The regulator has identified large cracks in some walls and ceilings, along with staining on the walls. We acknowledge these maintenance issues and will ensure they are promptly addressed by our maintenance personnel for repair. We are committed to rectifying these concerns to maintain a safe and comfortable environment for all residents.
The cleaning chart that was stored in the refuge area on the first floor has been removed

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:
We have reviewed and updated all individual care plans and assessments to ensure compliance with Regulation 5. This includes a thorough evaluation of the resident whose communication needs have changed,.We are committed to providing personalised care that meets the evolving needs of our residents.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
it was noted that our staff had not explored alternative options before administering PRN medication. We have recirculated the restrictive practice policy for staff to review and keep themselves updated. We will schedule refresher training for all team members. Staff have been informed that alternatives must be trialled and documented in the residents' care plans before PRN medication is administered.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
We will meet with the residents and staff to discuss whether the residents would like a different format with their activities. We will review the activity program together to determine what they would like to see implemented each day.

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 10(2)	The person in charge shall ensure that where a resident has specialist communication requirements, such requirements are recorded in the resident's care plan prepared under Regulation 5.	Substantially Compliant	Yellow	01/11/2024
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	01/12/2024
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	01/11/2024
Regulation 23(b)	The registered provider shall	Substantially Compliant	Yellow	01/11/2024

	ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.			
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	01/11/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	01/11/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements	Substantially Compliant	Yellow	01/11/2024

	recommended and details of the review process.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	01/11/2024
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	01/11/2024
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	Substantially Compliant	Yellow	01/11/2024

	consultation with the resident concerned and where appropriate that resident's family.			
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	01/12/2024
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	01/11/2024
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	01/11/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to	Substantially Compliant	Yellow	01/12/2024

	participate in activities in accordance with their interests and capacities.			