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:	Beech Lodge Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Kilmallock Road, Bruree, Limerick
Type of inspection:	Unannounced
Date of inspection:	07 November 2024
Centre ID:	OSV-0000408
Fieldwork ID:	MON-0045155

About the designated centre

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

Situated in the village of Bruree, County Limerick, Beech Lodge Care Facility offers long term care, rehabilitative care, respite care and convalescent care for older adults. The age range catered from is 18 to 65+. Our care facility is a 66-bed facility which is made up of 48 single en-suite bedrooms and nine double en-suite bedrooms. There is 24-hour nursing care available from a team of highly trained staff. Our mission is to promote the dignity and independence of residents. The designated centre provides short & long-term care, respite/convalescence and palliative care and care for residents' with dementia. Here at Beech Lodge an individual programme of activities is tailored to each individual resident. Referrals for admission may come from acute or long-term facilities, community services or privately. Private admissions are arranged following a pre-admission assessment of needs including medical background, dietary requirements etc. We aim to provide the best care possible and use a variety of care assessment tools to help us to do this. We also involve both the resident and their representative in this process. We provide a GP and physiotherapy service to all residents. We aim to make dining a social experience. Individual dietary requirements are incorporated into the menu planning process. Catering personnel are trained in the appropriate skills and are supported by the dietitian and the speech and language therapist (SALT). The facility has its own mini bus for the use of residents. There is a monthly residents' meeting to discuss issues ranging from activities, improvements in daily life, the environment and other issues. Activities include: newspapers, exercises, brain games, music, mass, art, baking, hairdresser, bingo, sensory therapy, and much more. We are interested in feedback to ensure that our service is continually reviewed in line with best practice. Visitors are welcome and local community events are accessible.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	63

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 7 November 2024	09:30hrs to 18:20hrs	Rachel Seoighthe	Lead

What residents told us and what inspectors observed

The overall feedback from residents living in the centre was that they were happy with the care they received and their life in the centre. While a small number of residents expressed concern about call bell response times, the majority of residents were complimentary in their feedback. The inspector observed that residents enjoyed a good quality of life, supported by a team of staff who were kind and responsive to their needs.

The inspector was greeted by the person in charge upon arrival to the centre. Following an introductory meeting with the management team, the inspector walked through the centre with the assistant director of nursing, giving an opportunity to meet with residents and staff. The inspector observed many residents relaxing in the communal seating areas, and some residents were in the process of getting ready for the day. The atmosphere in the centre was relaxed and welcoming.

Beech Lodge Care Facility is a purpose-built centre, located in the village of Bruree, Co. Limerick. The designated centre is registered to provide long term and respite care to a maximum of 66 residents. There were 63 residents living in the centre on the day of inspection. The centre was a two-storey, spacious facility and residents accommodation was provided in 48 single en-suite bedrooms and nine double en-suite bedrooms. Offices, storage rooms and staff facilities were located on the first floor of the centre. Resident living and bedroom accommodation was located on the ground floor which consisted of a main unit, with capacity for 51 residents, and a 15-bedded unit known as the Daffodil unit.

The entrance to the centre led to a reception area which contained seating and an aquarium for resident interest. There was an accessible dining room opposite the reception area and the inspector was greeted by several residents who were enjoying their breakfast on the morning of the inspection. Resident bedroom accommodation was located along corridors leading from the reception. The majority of residents were seen to socialise in the main communal sitting room, where activities took place throughout the day. The inspector noted that there was a constant staff presence here. There were a variety of other communal areas for residents to use including dining rooms, sitting rooms, a chapel and a music room. The enclosed outdoor garden area was well-maintained, and easily accessible for residents.

On a walk around the centre, the inspector observed that residents' private and communal accommodation areas appeared visibly clean and the interior of centre was well-maintained. However, the inspector noted that sluice rooms, although spacious in design, were cluttered with equipment and some surface areas were not clean.

The inspector was informed by the management team that the Daffodil unit, which had previously functioned as a secure dementia unit, had been decommissioned

since the previous inspection. On the day of inspection, the inspector observed that entrance doors to the unit could be opened without key code access. Residents' living in the Daffodil unit had unrestricted access to all communal areas within the centre. There were a variety of communal rooms within the unit itself, including a traditional style dining room and a spacious sitting room known as the 'Dome'. The centres' physiotherapy treatment room was also located in the unit. Resident bedroom doors were colourful and residents bedrooms were clean and tidy. There were appropriate handrails and grab-rails available in the bathrooms and along the corridors to support residents to move freely through the unit and maintain their safety.

The atmosphere in the Daffodil unit was relaxed and a group of residents were seen to be enjoying a ball game with activities staff in the Dome. Those residents who could not communicate their needs appeared comfortable and content. A small number of residents experienced responsive behaviours (how residents who are living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and the inspector noted that they were well supported by staff.

The inspector observed a number of pleasant staff and resident interactions throughout the inspection. Staff engaged in friendly conversation with residents, and it was evident that residents were comfortable in the company of staff. The inspector spoke with several residents throughout the inspection and feedback was generally positive regarding the quality of the service received.

There was evidence of information displayed throughout the centre guiding and informing residents about local activities as well as community services that were available. Daily menus and activity schedules were displayed in the reception area. Advocacy services were also available to support residents, and the contact details for these services were advertised in the designated centre.

Visitors were observed being welcomed into the centre throughout the inspection. Residents met with their friends and loved ones in their bedrooms or communal rooms.

The following sections of the report detail the findings with regard to the capacity of the provider to manage the centre, and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspector also followed up on the action taken by the provider, following an inspection in January 2024, to address issues of non-compliance. This inspection found that, while action had been taken to improve the

quality of the service and the care environment, the oversight of some management systems was not sufficiently robust to ensure full compliance with a number of regulations including notification of incidents, complaints, fire precautions and infection control.

Beech Lodge Care Facility Limited was the registered provider for Beech Lodge Nursing Home. The person in charge was newly appointed to their role and they were supported by an assistant director of nursing who deputised in their absence. Additional operational support and oversight was provided by a director of the company, that was the registered provider. A team of nurses, health care assistants, activity, administration, maintenance, domestic and catering staff made up the staffing compliment. There were a minimum of two registered nurses on duty in the centre, twenty four hours a day. Staffing levels were monitored by the provider and the management team informed the inspector that there was an ongoing recruitment plan in place. There was a staff training programme in place and training records reviewed demonstrated that staff were facilitated to attend training in fire safety, moving and handling practices, and the safeguarding of residents.

There was evidence of regular clinical governance meetings to review key clinical and operational aspects of the service. Records of these meetings were maintained and detailed the attendees, the agenda items discussed, and the actions that were agreed. Items discussed included care planning, incident management, audits and staff training.

There were management systems in place to oversee the service and the quality of care, which included a programme of auditing in clinical care and environmental safety. The inspector viewed a sample of audits in relation to wound care, nutrition and infection control. The inspector found that that most audits completed identified areas for improvement and had quality improvement plans developed. Audit findings were displayed in the centre, for staff information and learning. However, the inspector found that weekly call bell audits did not contain a quality improvement plan. Records demonstrated some occasions where unacceptable call bell response times were identified through the centre's monitoring systems, however there was no record of a time bound quality improvement plan to address this risk.

A record of all accidents and incidents involving residents that occurred in the centre was maintained. The majority of notifications required to be submitted to the Chief Inspector were done so in accordance with regulatory requirements. However, two notifiable incidents relating to potential safeguarding concerns had not been submitted to the Chief Inspector in the required time-frame, as required by Regulation 31.

A review of the complaints records found that not all concerns were acted upon in a timely and effective manner. This is detailed further under Regulation 34: Complaints procedure.

A directory of residents was maintained by the registered provider, however, it did not include all of the requirements of Regulation 19. For example, there were incomplete details in relation to residents' addresses, sex and marital status.

The inspector reviewed a sample of staff personnel files and found that they contained all the information, as required by Schedule 2 of the regulations. There was evidence that all staff had been appropriately vetted prior to commencing their respective role in the centre.

An annual report on the quality of the service had been completed for 2023 which had been done in consultation with residents and set out the service's level of compliance as assessed by the management team.

Regulation 14: Persons in charge

The person in charge was a registered nurse who was employed full-time in the designated centre. They had the required experience, skills and qualifications, as set out in the regulations.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, there was sufficient nursing and care staff on duty with appropriate knowledge and skills to meet the needs of residents and taking into account the size and layout of the centre. There were at least two nurses on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Training records reviewed demonstrated that staff were facilitated to attend training in fire safety, moving and handling practices, and the safeguarding vulnerable persons.

Judgment: Compliant

Regulation 19: Directory of residents

A review of the directory of residents found that the information specified in Schedule 3 was not entered into the directory for multiple residents as follows;

- the name and address of any authority, organisation or other body which arranged the resident's admission to the designated centre.
- the name and address of the residents' general practitioner.
- the residents' home address, sex and marital status.

Judgment: Substantially compliant

Regulation 23: Governance and management

Some of the management systems in place to ensure that the service was safe and monitored were not fully effective. This is evidenced by:

- Call bell audits were not progressed to completion. For example,weekly call bell reports generated by the clinical management team demonstrated that there were some occasions where call bell response times were unacceptable. However, a time bound quality improvement plan was not devised to address the risk identified.
- There was inadequate management oversight of complaints, records and notification management, fire precautions and infection control.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had not notified the Chief Inspector of two potential safeguarding incidents, within the required timeframe, as required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector found that complaints management was not in line with regulatory requirements or the centres' own complaints policy. For example:

- A record of investigation was not available for two complaints reviewed, consequently the complaint resolution and the complainant satisfaction level was not recorded.

Judgment: Substantially compliant

Quality and safety

Overall, this inspection found that residents living in the centre were receiving good quality clinical care, in line with their assessed needs. A restrictive practice which had been in place was removed through decommissioning the secure dementia unit, which helped to ensure that resident choice and freedom of movement were optimised. Staff demonstrated good knowledge of resident care needs and interactions were kind and respectful. Notwithstanding this positive finding, fire precautions and infection control did not meet full compliance with the regulations.

The management of fire safety was kept under review and there were arrangements in place for the testing and maintenance of the fire alarm system, emergency lighting and fire-fighting equipment. Records demonstrated that management carried out daily checks of means of escape to ensure they were not obstructed, and weekly checks to ensure that equipment was accessible and functioning. Staff had received fire safety training. However, the inspector found that some of the fire doors did not provide assurance of effective containment of smoke and fire in the event of a fire safety emergency. This is addressed under Regulation 28: Fire precautions.

Some action had been taken to address issues of non-compliance in relation to infection prevention and control found on a previous inspection. Overall, the inspector observed that the general environment, including residents' bedrooms, communal areas and toilets appeared visibly clean. The inspector identified some examples of good practice in the prevention and control of infection. For example, staff were observed to apply basic infection prevention and control measures to minimise risk to residents such as hand hygiene and use of personal protective equipment. Laundry facilities were observed to be clean and tidy. However, the cleanliness and organisation of two sluice rooms did not ensure that good standards for infection prevention and control were maintained. This finding is discussed under Regulation 27: Infection control.

Overall, the design and layout of the premises was suitable for its stated purpose and met the residents' individual and collective needs. The centre was found to be well-lit and warm. Residents' bedroom accommodation was bright and individually personalised,and residents had sufficient storage space for their personal possessions.

The centre had an electronic resident care record system. Pre-admission assessments were undertaken by the person in charge, to ensure that the centre could provide appropriate care and services to the person being admitted. A number of validated nursing tools were used to assess residents' care needs. Care plans were informed through the assessment process and developed in consultation with

residents. A sample of resident care plans were noted to be person-centred, and reviewed in line with regulatory requirements.

Residents had access to medical care and records demonstrated that referral systems were in place for residents to access allied health and social care professionals, such as dietitians, tissue viability specialists, and speech and language therapists, for additional support and expertise. A physiotherapist attended the centre twice weekly.

The registered provider had measures in place to safeguard residents from abuse. The provider acted as a pension-agent for six residents. Records which detailed each resident's payment and surplus amounts were available to review. There was also a procedure in place for the management of residents' petty cash. There was a policy and a procedure available for safeguarding vulnerable adults and training records identified that staff had participated in training in adult protection.

There were arrangements in place for residents to access advocacy services. Records demonstrated that resident meetings were convened and that there was discussion around various topics including services, food, and activities. Residents spoken with were complimentary of the staff and the care they provided. Residents had access to television, radios, books and newspapers. Two members of staff were assigned to provide activities and the schedule of activities included exercise programmes, art, music and outings.

Visiting arrangements were flexible, with visitors being welcomed into the centre throughout the day of the inspection. The inspector saw that residents could receive visitors in their bedrooms or in a number of communal rooms.

Regulation 11: Visits

The provider had ensured that visiting arrangements were in place for residents to meet with their visitors as they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Each resident had adequate storage in their bedrooms and were able to access and maintain control over their clothing and personal possessions. Residents' personal clothing was laundered in the centre's laundry and arrangements were in place to ensure their clothing was returned to them following the laundering process.

Judgment: Compliant

Regulation 27: Infection control

A number of issues were identified which had the potential to impact the effectiveness of infection prevention and control within the centre. This was evidenced by:

- Sluice rooms did not facilitate effective infection prevention and control measures. For example, the sluice room in both the main centre and daffodil unit were cluttered with equipment and the sink surface area in one sluice room was not clean.
- Continence equipment drying racks without drip collection trays, were positioned directly over sink surfaces, which may pose a risk of contamination.
- The floor surface of the smoking room was visibly unclean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The arrangements in place to ensure that the containment of fire in the event of an emergency was not adequate. For example:

- Two cross corridor doors in the Daffodil Unit did not close fully to form a seal. This could compromise the effective containment of smoke and fire in the event of a fire emergency.
- A door hold-open device was not operating in one resident bedroom and the door was held open by a piece of furniture.

The provider did not have adequate precautions against the risk of fire in place. For example:

- The storeroom in the Rose corridor contained combustible supplies stored in close proximity to electrical equipment. This may increase the risk of fire in this area.
- The smoking apron in the designated smoking room was in a poor state of repair.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents had up-to-date assessments and care plans in place. Care plans were person-centred and reflected residents' needs and the supports they required to maximise their quality of life.

Judgment: Compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP), and the person in charge confirmed that GPs were visiting the centre, as required.

Residents also had access to a range of allied health care professionals such as physiotherapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age, and palliative care.

Judgment: Compliant

Regulation 8: Protection

Measures were in place to safeguard residents from abuse. These included arrangements in place to ensure all allegations of abuse were addressed and managed appropriately to ensure residents were safeguarded.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the premises met the residents' individual and collective needs. The premises were well maintained internally and externally.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 17: Premises	Compliant

Compliance Plan for Beech Lodge Care Facility OSV-0000408

Inspection ID: MON-0045155

Date of inspection: 07/11/2024

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: Gaps in the Directory of Residents have now been addressed - completed. Monthly audits on the Directory will be completed to ensure ongoing compliance – commencing January 2025.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Call Bell data for the last quarter has now been analysed and trended with feedback provided to care staff and a copy has been provided to the inspector – complete. As part of the Quality Improvement Plan developed the Senior Nurse and Care Leads will now conduct daily monitoring of call bells in each unit to ensure timely responses. Additionally, senior management will perform additional manual weekly call bell audits to supplement the data derived from the automated system. The results of both of these audits will be combined, analysed and trended and discussed at clinical governance meetings – commenced from 28th November 2024. A Call Bell Champion is now assigned on each shift, tasked with ensuring prompt responses to residents' needs and upholding high standards of care. Any reports of delays in answering call bells will be escalated to senior management, thoroughly investigated, with appropriate actions taken and issues resolved promptly – commenced from 2nd December 2024. A new system of clinical and operational governance has been introduced in the centre	

which includes:
• a mix of daily and weekly audits and walkabouts,
• thorough KPI monitoring (which is reviewed by an independent nurse consultant on an individual resident basis with feedback to care staff)
• review and discussion on incidents, accidents and complaints (together with any statutory notifications required, investigations conducted and follow up of same)

Minutes are recorded with actions clearly identified – commenced from 6th October 2024.

Please also refer to the actions outlined in the fire compliance section, as specified in Regulation 28.

Regulation 31: Notification of incidents	Not Compliant

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

A new system of clinical and operational governance has been introduced in the centre including reviewing and discussion on incidents, accidents and complaints (together with any statutory notifications required, investigations conducted and follow up of same).

Notifications were submitted after the inspection

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

The two complaints referred to were thoroughly investigated post the inspection with an outcome letter sent to each complainant. Both complaints are now closed to the satisfaction of each party – complete.

The senior management team now conducts additional weekly check-ins with all residents to ensure that any complaints are identified, recorded, and resolved to the satisfaction of the residents -commenced from 18th November 2024.

Furthermore, complaints received are now reported on as part of the Key Performance Indicators and discussed at weekly Clinical Governance meetings – commenced from 6th October 2024.

Regulation 27: Infection control	Substantially Compliant

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

Weekly IPC walkabout inspections have now commenced by Senior nurses with feedback given directly to staff members on duty where any issues arise – commenced from 28th November 2024.

A drip collection tray will be installed beneath the drying rack in the Daffodil sluice room to prevent cross-contamination. Parts has been ordered and a new drying rack with drip collection tray will installed before the end of January 2025.

Staining on the smoke room floor was addressed and cleaned on the day of the inspection – complete.

Additional training has been scheduled for household staff on the use of chemicals and cleaning standards by an independent expert – scheduled for 18th December 2024.

Regulation 28: Fire precautions	Substantially Compliant

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

The two cross corridor fire doors and one door hold-open device have all been addressed and made safe – complete. A review of all other fire doors by a "competent person" is planned for January 2025, and any parts that need replacing will be ordered.

Combustible materials stored near electrical equipment, as identified during the inspection, have been removed - complete.

All staff have been reminded that doors must not be held open by any means and the correct storage of combustible items, and regular spot checks will be conducted by senior management to enforce these policies – Staff communication session held last 11th November 2024 and ongoing.

The smoking apron in the designated smoking room has been replaced to ensure resident safety - complete.

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 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	22/11/2024
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.	Substantially Compliant	Yellow	05/03/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are	Substantially Compliant	Yellow	05/02/2025

	implemented by staff.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	05/05/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	05/05/2025
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	05/01/2025
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	05/01/2025