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:	Cherry Orchard Hospital
Name of provider:	Health Service Executive
Address of centre:	Cherry Orchard Hospital, Ballyfermot, Dublin 10
Type of inspection:	Unannounced
Date of inspection:	27 May 2024
Centre ID:	OSV-0000508
Fieldwork ID:	MON-0041742

About the designated centre

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

This centre comprises of 113 continuing elderly care beds. The centre is registered to provide 24-hour care to male and female residents. Full nursing care is available based on individualised care planning. Education is provided for nursing staff so that residents with all levels of medical needs can be cared for in the units. Health care assistants work with the registered nursing staff to provide a high standard of care to all clients. The nursing staff work under the guidance of the ward manager, supported by clinical nurse specialists and nursing administration. Included in the staff is a Clinical Nurse Specialist (CNS) in behavioural therapy and dementia. Other services are available from social and health care professionals, which include physiotherapy, occupational therapy, and social work, and there is a chaplaincy programme. The residential facilities compromise of four units- The Beech, Aspen, Willow and Sycamore. The bed capacities range from 12 to 43 residents. It is composed of single, twin, and triple-bedded bedrooms. Beech and Aspen are dementia-specific units. Both the Willow and Sycamore units have a large sitting room, dining room, physiotherapy room, occupational therapy room, snoezelen room, activity room, and a quiet room/communal room. There is also access to a large secure garden and smaller gardens.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

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
Monday 27 May 2024	07:50hrs to 19:30hrs	Helena Budzicz	Lead
Monday 27 May 2024	07:50hrs to 19:30hrs	Manuela Cristea	Support
Monday 27 May 2024	07:50hrs to 19:30hrs	Susan Cliffe	Support

What residents told us and what inspectors observed

During this inspection, a calm and comfortable environment was observed within Cherry Orchard Hospital. The inspectors witnessed the care and activities provided to residents, engaged in conversations with both residents and staff and observed the care environment. The residents, who appeared at ease, expressed contentment with the care they received within the centre. The inspectors had the opportunity to meet with all residents, engaging in more detailed conversations with 11 residents and several visitors to gain a deeper understanding of their experience.

The majority of feedback from residents was positive, particularly highlighting the profound impact of the staff's kindness on their well-being. One family member expressed a deep sense of relief and satisfaction when their loved one came to live in the centre. They were particularly pleased with the continuity of care provided by the same staff members, the kindness and attentiveness of the staff, and the regular updates they received about their relative's care.

Residents' accommodation and living space were laid out over four units, Aspen, Beech, Sycamore, and Willow, within a campus-style setting. Due to pending structural and fire safety works, the number of residents living in the Sycamore and Willow units of the centre has reduced significantly. As part of this inspection, inspectors observed the quality of life and care environment of the 15 residents accommodated in the Sycamore and Willow units.

The occupied bedrooms in the Sycamore and Willow units were personalised for each resident, containing family photographs and personal belongings. These bedrooms were clean; however, the vacant rooms and bedrooms in these two units had not been cleaned and maintained. Some of these vacant bedrooms were furnished with the necessary equipment to accommodate residents, such as beds, chairs, and mattresses. However, inspectors observed dust and watermarks on the floor, heavily marked and damaged floors, and stained sinks in these registered bedrooms and en-suites.

Inspectors arrived early at the centre and observed that the breakfast experience for the residents in the Sycamore and Willow units was not fully supportive of their rights. All residents were served breakfast in bed, and breakfast was served in covered plastic bowls and cups. Staff in the centre told the inspectors that this was to ensure residents' safety. However, no risk assessment had been carried out to inform a tailored approach based on residents' individualised needs, and instead, a blanket approach had been taken to all residents, which did not promote a positive mealtime experience. In addition, inspectors reviewed the food stored in the kitchen and observed open, unlabeled items, which is not in line with food safety principles.

Areas of the outside space allocated for the residents of these units were not maintained, with overgrown grass and empty food containers lying around in front

of the Willow and Sycamore unit. In addition, access to some of the outside gardens was restricted by a key-pad code, which was not available to residents.

The inspectors also observed that some of the internal fire doors were not closing correctly or had missing intumescent strips. This could reduce the effectiveness of the fire door in the even of a fire emergency. This risk had been identified on a previous inspection of the centre.

On a positive note, inspectors observed improvements in the lived environment for the residents accommodated in the Aspen and Beech units. The walls were nicely painted and decorated, there was new furniture in place, and the residents complimented their rooms. However, the garden and the outside sitting area in front of the Aspen unit were not well-maintained to support a positive outdoor experience, and some of the paths presented health and safety risks for residents. Inside the unit, the inspectors observed that some of the facilities, such as communal family rooms and residents' bathrooms, were locked. Such practice did not support a restraint-free environment and did not uphold residents' rights to access all communal areas in the unit. The inspectors acknowledge that these restrictive practices were identified by the local clinical management of the Aspen unit, and there was evidence of active engagement to address this issue.

A schedule of activities was readily available for residents' reference and conveniently placed at appropriate locations. Each unit had dedicated activity staff, ensuring residents were well-supported in engaging in meaningful activities throughout the day. These activities included interactive sessions using light therapy, sensory therapy in the snoozelen rooms, exercise sessions, and music. The residents, particularly those receiving one to one supervisory care, were observed to enjoy these activities in the company of the staff members.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect the quality and safety of the service being delivered.

Capacity and capability

Overall, the findings of this inspection and assurances received from the provider immediately after the inspection were that the registered provider of Cherry Orchard Hospital showed a willingness to work towards achieving regulatory compliance and addressing the identified issues in the Sycamore and Willow unit. However, this inspection found that the management oversight of the centre was not fully effective. Specifically, the supervision of staff practices and the monitoring of care and services provided to residents were not effective. Improvements were also required in relation to many other aspects of the operation of the designated centre, which will be detailed under the relevant regulations of this report.

This was an unannounced inspection, carried out over one day by inspectors of social services, to monitor the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This inspection also reviewed the registered provider's implementation of their compliance plan submitted following a previous inspection in May 2023 and information submitted as part of the provider's application to renew the registration of this designated centre.

The Health Service Executive (HSE) is the registered provider for the designated centre. As a national provider providing residential services for older people, the designated centre has access to and support from centralised departments such as human resources, accounts, and information technology.

Inspectors found confused lines of accountability and responsibility in the designated centre, which were not in line with the statement of purpose. Inspectors found confusion among some staff and residents as to whether they were living or working in a designated centre for older people or a designated centre for adults with a disability, two different registered services co-located on this one campus. Similar to the findings of the last inspection, inspectors found inappropriate intermingling of resources between these two separately registered services, which meant that the resources which should have been available for the designated centre for older people in Cherry Orchard Hospital were not.

- The lines of accountability and responsibility were unclear. For example, the clinical nurse manager in the Beech unit reported to the management personnel from the disability service and not the person in charge of older person services.
- Responsibility for the oversight of the individual units' Key Performance Indicators (KPIs), audits, complaints and incidents and accidents and to submit the statutory notifications to the office of the Chief Inspector was outsourced to a manager in the disability services.
- Personnel from the disability services were nominated to deputise in the absence of the person in charge and were rostered to provide oversight of the residential service on set days.
- The roster available to inspectors indicated that the management personnel from older person services were providing management oversight to two units on the campus registered with disability services.

These arrangements were not appropriate and did not support accountability, effective governance and management of service.

For example, the mixed structure impacted the management and oversight of the notifications of incidents. There were several statutory notifications, some dating as far back as 2023, that had not been followed up and had outstanding information requests; these were received following the inspection. There was insufficient assurance that all incidents were identified and notified in a timely manner. A review of the complaints log found that a number of safeguarding concerns identified within a complaint had not been identified as such and, therefore, had not been managed

in line with the centre's safeguarding policy. Subsequently, they were not notified to the office of the Chief Inspector.

In addition, while there were systems in place to audit some aspects of the service, such as care plans and infection prevention and control. While these audits included an analysis of the findings, the quality improvement action plan was not effectively implemented to ensure that identified issues were addressed.

An annual review of the quality and safety of care delivered to residents for 2023 had been completed; however, it did not include a comprehensive analysis of the quality and safety of the care provided and did not identify any areas for improvement for 2024. In addition, there was no evidence that this review was completed in consultation with residents and their families.

Contracts of care were not in place for all residents. A sample of reviewed contracts of care did not meet all regulatory requirements. The centre's policies and procedures, as set out under Schedule 5 of the regulations, were incomplete and had not been reviewed as required.

There were inadequate arrangements in place in respect of the management and supervision of volunteers, including having appropriate garda clearance in place as required.

Following the inspections, assurances were received that effective arrangements had been made to separate the governance and management structure per service provided in line with the requirements of the regulations.

Registration Regulation 4: Application for registration or renewal of registration

An application to renew registration of the designated centre in accordance with the requirements set out in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 had been made by the registered provider. This application was in the process of being reviewed at the time of inspection.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents was maintained in electronic format and contained all the information as per the regulatory requirement.

Judgment: Compliant

Regulation 21: Records

A sample of staff files were examined, and the registered provider had not ensured that records were maintained in compliance with regulatory requirements as outlined in Schedule 2 as follows:

- One staff file included some inconsistent information, did not have any references in place, and the details of the previous experience were also missing.
- The financial statements for residents were not available. There was no evidence of financial balances, including monies received to the account, the amount of money charged for the services, and monies left on the account.
- Records underpinning pension agent arrangements were incomplete.

Judgment: Not compliant

Regulation 22: Insurance

The provider had an up-to-date insurance contract in place against injury to residents and loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

There was not a clearly defined management structure in place that identified the lines of authority and accountability and detailed responsibility for all areas of care provision. For example:

- Governance and management structures, which were meant to be in place for the designated centre for older people, were shared across two co-located services: a designated centre for older people and a designated centre for adults with a disability. This was a repeat finding from the last inspection, and the HSE had not adhered to its commitment to ensure that each registered service had its own accountable governance and management team.
- The deputising arrangements in the absence of the person in charge included management personnel from the disability service. These arrangements were not in line with the requirements of the regulations for older person services and posed a risk to the oversight of service.

Governance and management systems in place did not ensure that the service provided was safe, appropriate, consistent and effectively monitored. For example:

- Audits were completed locally by the nursing staff on each of the individual units. They were then sent to the person in charge and the administration staff for evaluation. However, these audits did not identify the known risks in the centre. For example, the infection prevention and control audits had failed to identify the deficits in environmental cleanliness seen in the Willow and Sycamore units.
- The oversight and management of fire safety risks in the centre were found to be inadequate. Inspectors observed several fire doors not closing fully, latching against the floor, and intumescent strip was also missing on one of the fire doors. This was a recurrent finding from the previous inspection.
- The oversight of incidents and complaints in the centre was not effective. The learning from incidents and complaints was not routinely shared with the individual units to drive improvements and to inform the follow-up on the actions implemented. Once completed, the incident/complaint forms were sent to an administration office, and the local management of the units did not know the outcome. The inspectors found that two complaints were not recognised as potential safeguarding allegations. These notifications were submitted retrospectively.
- The incident and accident log provided to inspectors was not comprehensive and sufficiently robust to provide a meaningful overview of the trends and patterns of risk in the designated centre. The inspectors were provided with a print-out summary of the incidents.
- The registered provider had not ensured that appropriate systems were in place to safeguard the residents and their finances. For example, there was a lack of assurance that volunteers were appropriately supervised and had a Garda vetting disclosure in place. Contracts of care were not in place or well-maintained, and the financial arrangements, as detailed under Regulation 8: Protection were not maintained in line with national guidance and legal requirements.
- There was inadequate oversight of quality systems to ensure that residents' rights were promoted and upheld and that a person-centred culture was at the heart of service provision. This was evident in task-oriented practices such as the serving of breakfast, inappropriate use of restrictive practices as well as care planning arrangements that were not consistently evidence-based and person-centred.
- The systems in place to monitor environmental hygiene and the state of internal and external premises were inadequate. They did not ensure that the centre was cleaned and maintained to an appropriate standard, to support a dignified living environment and provide access to outdoor spaces that promoted residents' independence and quality of life.
- The oversight of maintenance systems was poor. A bedpan washer had been out-of-order since April, and it was difficult to trace whether it had been serviced. The information in respect of the servicing of this equipment was not available in the unit where this bedpan washer was located and the local management team were not aware of its status.

While the annual review for 2024 was available for review, there was no evidence of quality and safety of care analysis to identify deficits, which would drive the improvement plan and actions for next year. In addition, there was no evidence that this review was prepared in consultation with residents and their families.

Following the inspection, a comprehensive immediate action overview with detailed actions put in place and a plan for how the centre is planning to come into compliance was received.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Not all residents had a contract of care in place on the day of inspection.

The inspectors reviewed a sample of contracts for the provision of services and found that these contracts did not clearly indicate the following:

- Several residents did not have contracts of care in place for several years since their admission. The centre's management informed the inspectors that they had identified this issue and were in the process of implementing new contracts of care for all residents.
- There was no room number identified in residents' contracts and no specification of whether the room was single or the number of occupants in that room.
- The weekly charge for the service did not specify if this fee was paid under the Nursing Homes Support Scheme or private contribution.

Judgment: Not compliant

Regulation 3: Statement of purpose

The Statement of purpose (SOP) did not comply with regulatory requirements:

- The staffing complement did not accurately reflect the members of management personnel employed in the centre. These members were also involved in the management of the disability services units on campus.
- The arrangements in place for the senior management support in the centre were not outlined.
- The SOP did not outline some of the facilities necessary for the centre, such as the laundry, administration building, and archives.

Judgment: Substantially compliant

Regulation 30: Volunteers

Volunteers who attended the centre had no file in place. The roles and responsibilities were not set out in writing, and there were no arrangements for supervision and support. There was also no vetting disclosure in place in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of the records in relation to incidents and complaints in one of the units in the centre showed that there were two potential safeguarding incidents, that were not notified in full to the office of the Chief Inspector within the required time frames as set out in Schedule 4 of the regulations. These notifications were submitted following the inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints procedure and policy, which aligned with the requirement of Regulation 34.

Judgment: Compliant

Regulation 4: Written policies and procedures

Action was required to ensure Schedule 5 policies and procedures were reviewed, updated and implemented to reflect legislation, for example:

- A number of policies available were mixed with the disability service and did not reflect the needs of the older people living in this designated centre for older people.

- The policy on 'Monitoring and documentation of nutritional intake' was not reviewed at intervals not exceeding three years as required by the regulations.
- There was no policy available on the 'The creation of, access to, retention of, maintenance of and destruction of records'.
- While the policy on 'Residents' personal property, personal finances and possessions' was available in the centre, it did not reflect the latest national policy and guidelines.

Judgment: Not compliant

Quality and safety

While the inspectors observed kind and compassionate staff treating the residents with dignity and respect, the systems overseeing the service's quality and safety were not sufficiently robust. Specific detail in respect of required actions is provided under the following regulations: premises, infection control, medication management, managing behaviours that are challenging, restrictive practices, protection, residents' rights, assessments and care plans and information for residents.

On the day of inspection, a selection of care plans were reviewed. The inspectors were assured that the care plans and validated assessment tools were in place within 48 hrs of admission. However, care plans were not developed in line with the assessments completed as accurate information was not always recorded to effectively guide and direct the care of residents with weight loss, dysphagia (difficulties with swallowing), medication administration management, infections, and protective measures following safeguarding incidents. These findings are outlined under Regulation 5: Individual assessment and care plan.

Residents living with dementia and those with responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had associated care plans in place; however, the behavioural support care plans and some environmental restrictive practices implemented in the centre were not in line with the requirements of the regulations.

The care environment was observed to be in a poor state of repair, both internally and externally. Ventilation issues were observed in some of the ancillary facilities, such as communal bathrooms and a dirty utility room. These and other findings are outlined under Regulation 17: Premises.

A number of practices were identified that had the potential to impact the effectiveness of environmental hygiene within the centre. For example, not all areas used by residents, such as the snoozelen room, were cleaned to an appropriate

standard. In addition, some of the decontamination practices required review, as discussed further under Regulation 27.

The provider had not taken adequate measures to ensure that residents were adequately safeguarded from any risk of financial abuse and neglect.

There were arrangements in place for residents to access independent advocacy services. There were facilities for recreation and some opportunities to engage in activities. However, inspectors observed practices that needed to be more person-centred and did not ensure that residents' rights and choices were always promoted in the centre. This is detailed under Regulation 9: Residents' rights.

Regulation 17: Premises

The inspectors found that further action was required to ensure that the premises complied with the requirements of Schedule 6 of the regulations. For example;

- The premises were not kept in good order internally and externally. For example, the outside space and garden outside the Willow, Sycamore, and Aspen units were not well-maintained. There were broken pots, unclean garden furniture, empty food trays, and cigarette buts outside the residents' communal areas.
- Internally, in the Willow and Sycamore units, as per previous inspection findings, the flooring in these units on the main escape corridors and the en-suites appeared to be bouncy, uneven, and unstable and could pose a risk to mobilising residents. The provider had a plan in place to remedy this issue.
- There were no emergency call-bells in the Family/ Palliative care room and Snoozelen room in the Aspen unit. This meant that residents using these rooms were not facilitated to call for assistance.
- There was inadequate ventilation in the Beech unit, evidenced by strong odours in one of the assisted toilets and the dirty utility area. The shower room had a musty smell, and the flooring was water-stained.
- Inspectors identified a bedpan washer that had been out of order since April.

Judgment: Not compliant

Regulation 20: Information for residents

The provider prepared a guide for residents; however, the terms and conditions relating to residence in the centre were not clearly outlined, and the information about 'Personal property and finance' did not refer to the correct HSE guidelines. In addition, the complaints policy referred to review processes, which were not in line with the relevant regulations.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a comprehensive risk management policy and risk register in place which assessed all identified risks (potential and actual), and outlined the measures and actions in place to mitigate and control such risks.

Judgment: Compliant

Regulation 27: Infection control

The equipment and the environment were not managed in a way that minimised the risk of transmitting a health care-associated infection. This was evidenced by:

- Cleaning of all areas had not been completed, especially in the Willow and Sycamore units. For example, the windows, sinks and floors were unclean, stained and covered with grease. The kitchen was also unclean, and inspectors observed a dirty mop on the floor, which posed a risk of cross-contamination. There were significant gaps in the deep cleaning schedules, and this had not been identified by the registered provider.
- The Snoozelen room in the Sycamore unit was dusty and unclean, and the floor was sticky and heavily marked. This room was observed to be used by residents during the day, and this environment did not support a dignified experience.
- The laundry trolleys were heavily stained and covered with mould.
- The staff practices and the decontamination process in the centre did not adhere to local policy and infection control guidelines. For example, the cleaning product bottles observed in use were not labelled and dated as per best practice; the procedure to ensure that the chemical bottles were decanted, cleaned and left to dry after use was not implemented and followed by staff.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors were not assured that all medicinal products were stored securely in the centre. For example, nutritional supplements were seen to be stored in the centre's pantries. This meant that there was inadequate oversight of the medicine

stock available at any time. Inspectors observed that no prescription was available from the prescriber for some of the supplements, and the supplements that were no longer required were not disposed of in accordance with national legislation or guidance.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

While incidents of responsive behaviour were recorded, the care plans were not always updated following such incidents, therefore the care plans in place did not reflect the behavioural patterns or triggers that led to these behaviours. The care plans were generic and mainly referred to 'observe' and 'monitor' the resident and 're-orientate and to re-assure' the resident. Care plans did not clearly describe the person-centred techniques to support the residents and staff navigate this behaviour.

Inspectors observed some specific restrictive environmental practices that did not support residents moving freely in the centre. For example:

- The doors into the garden were locked with a key-pad code in the Aspen unit and in some parts of the Willow and Sycamore units. In the Aspen unit, two assisted toilets and a shower were locked with a code lock on the door handle, and there was a note, 'Ask a member of staff for assistance'. This did not uphold residents' rights.
- The visitors/palliative care room was locked with a key in the Beech unit and, therefore, not available to residents.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not taken all reasonable measures to ensure residents were safeguarded and protected from abuse, as evidenced by the following:

- From a review of 13 residents' files for whom the registered provider was a pension agent, it was found that six residents had no pension form available to instruct and appoint an agent to manage their pension. The forms were poorly completed: seven residents had no person nominated on the form to act as the pension agent, and the forms were not signed. Some of the forms were dated back to 2020. Following the inspection, supportive information was received in respect of two residents with a copy of their completed forms and an explanation as to why these forms were not held in the local centre.

- The financial arrangements for residents who had died in the centre were not adequate. Money was left unaccounted for, and inspectors were not assured that appropriate arrangements had been made to inform the residents' estate or representatives.
- The provider had failed to recognise and respond appropriately to two allegations of abuse received via the complaint process. As a result, there was no investigation into these allegations and no assurance that the concerns raised were managed according to the centre's safeguarding policy and that appropriate protections were put in place in respect of two residents.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider did not ensure that residents were consulted about or had opportunities to participate in the organisation of the designated centre. For example;

- Notwithstanding the engagement with residents and their relatives in respect of proposed transfers from Willow and Sycamore units, there was little evidence that consent was regularly sought or received before transferring residents from one bedroom to another. The inspectors found that one resident had been moved on four different occasions between the units in the last 12 years, and no consent or agreed contract of care was available.
- Residents were not regularly provided with a financial statement to enable them to make informed choices in respect of how they wished to live their life. For example, one resident had accumulated a large sum of money, and the resident was not aware of the same, nor were they afforded any additional activities, such as outings, that might have improved their quality of their life.

Residents' rights to exercise choice were not consistently upheld. For example, access to communal facilities such as assisted toilets or visitors room was restricted in some of the units. In the absence of an individualised risk assessment, all residents in Willow and Sycamore units were served breakfast in plastic crockery.

Emergency call-bell chords were not accessible in some of the communal toilets in the Aspen unit as they were tied up high and away from residents' reach, which posed a risk that when a resident required help, they would not be able to reach them.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Care plans were not updated based on the current resident's condition and did not provide accurate details on the care to be delivered to residents. For example:

- Care plans relating to the management of COVID-19 infection were still in place when the resident had this infection back in 2022, with the same measures of care and infection control precautions in place.
- The care plan for crushed medication administration was not updated to reflect the current consistency of food and fluid levels based on the latest Speech and language therapy (SALT) recommendation.
- The nutritional care plan for a resident with a recent history of weight loss and receiving a nutritional supplement was not updated to reflect this.
- Safeguarding was not incorporated into the care plans of two residents involved in safeguarding incidents.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant

Compliance Plan for Cherry Orchard Hospital OSV-0000508

Inspection ID: MON-0041742

Date of inspection: 27/05/2024

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 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

• Missing information (references and details of previous experience) for one staff file updated – Completion date 4/06/2024

• Designated centre completed an audit review of all staff files – Completion date 31/08/2024

• Designated centre will review the Pension Agent arrangement process onsite to ensure relevant resident's finances are protected. The Registered Provider will provide regular updates on the review to the regulator- Completion date 31/12/24

• A nominated member of the designated centre will directly support engagement with residents where HSE is the pension agent on a bi-monthly basis or more frequently if required to enable and support residents to make informed choices to utilise their finances to enhance their residential care experience based on their personal preferences. This includes:
· Providing a breakdown on what finances are available to them and how this can be accessed
· Exploring spending options based on personal interests/preferences e.g. sourcing cinema/concert ticket etc.
· Develop and document individual person-centred social care plans utilising available funds to enhance the quality of their care
· Timely follow up on any individual queries
This engagement will be supported by the individual units Clinical Nurse Managers and Social Workers - Completion target date 31/12/24

• Designated centre will keep a copy of signed completed Pension Agent application forms onsite - Completion date 14/10/2024

Regulation 23: Governance and management	Not Compliant

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

• Designated centre's existing governance structures was reviewed and this structure for authority and accountability is now within the remit of the designated centre for older persons as per the regulatory requirement for a stand-alone centre (administration roster/policies for OPS designated centre) – Completed 29/07/2024

• Deputising arrangements in the absence of the person in charge only include management personnel from the older persons designated centre in line with the requirements of the regulations for older person services – Completed 17/06/2024

• Develop and implement a COH Governance Policy to provide a clear oversight of the designated centre management processes – Completion target 31/09/24

• Strengthen the designated centre individual units operational oversight of audits ensuring all identified deficits (in particular IPC/Cleaning audits) are addressed through a time bound QIP allocated to individual designated staff and supported by a status update requirement to the Person in Charge – Completion target 31/12/24

• The Centre's Fire officer completed a fire safety audit across the centre with a particular focus on fire doors not closing fully, latching against the floor and intumescent strip. The fire officer will complete a time bound action plan to address deficits identified- Completion target date 27/5/25

• Review and strengthen the individual unit governance oversight of incidents, complaints and safeguarding within the designated centre. This includes a standardize feedback process between the individual unit managers, all relevant staff and senior management team to promote sharing of evidence based practice, timely escalation of risk across the centre - Completion target date 30/9/24

• Quarterly trend analysis of incidents/complaints/safeguarding logs with findings reported at the Quality and Patient Safety meeting to identify any patterns of risk and quality improvement actions required – Completion target date 1/10/2024

• A review of financial statements on all residents, who the HSE are pension agents found that financial statements were sent to the individual units in COH. This process has been amended and now all quarterly financial statements will be sent to the administration office in COH and a member of staff will engage with the individual residents to enable them to make informed choices regarding financial arrangements– Completion target date 2/12/2024

• Review and strengthen contract of care governance oversight to ensure they are updated regularly where required with a particular focus on financial arrangement (see regulation 8) This includes status report provided at monthly CNMII meetings– Completion target date 01/10/2024

• Care Plan audit in relation to be completed by individual unit managers (CNMII) with a particular focus on applying person-centered techniques and ensuring that residents will and preference is documented in care plans. There will be a focus on the responses to responsive behavior and activities of daily living including dining and cutlery use - Completion target date 31/12/2024

• Enhance the designated centre's existing quality improvement systems to ensure residents' rights continue to be central to the planning and delivery of services advocating a person-centred culture to ensure an evidenced and person centred approach. Key actions to be completed - Completion date 19/08/2024

• Individual risk assessment and resident engagement to be completed where polycarbonate crockery usage is being considered for resident's with dementia or mobility issues- Completion date 19/08/2024

Centre's Catering manager had introduced polycarbonate plastic bowls, which have low heat conductivity properties and keeps food warm for longer to enhance the mealtime experience for residents with dementia or mobility issues who are slow to eat due to environmental distractions. If this is introduced for residents it will be supported by a risk assessment and resident engagement and documented in individual care pan
· Residents' personal preferences in relation to getting out of bed for breakfast will be documented in individual resident's care plan
· Currently the changes and consent for bed or room transfers is documented in resident's records. The service will now also keep a copy of all moves in the resident's contract of care. Contract of Care updates will be an agenda item at CNMIIs monthly meeting
· All quarterly financial statements will be sent to the administration office in COH and a delegated admin staff will engage directly with the relevant individual residents to enable them to make informed choices regarding financial arrangements.

• All communal facilities to be reviewed to ensure full access to residents. This is supported by an open access sign placed on all communal facilities to remind staff to maintain open access and to orientate relatives to its usage. Access checked as part of the daily walk around check by the individual unit managers- Completion date 19/08/2024

• Emergency call-bell chords accessible in the communal toilets in the Aspen unit – Completion date 29/05/2024

• Review current contract for outside spaces with the HSE maintenance department with the aim of improving the ongoing maintenance of the outside garden spaces for each individual unit - Completion target date 31/12/24

• Designated Centre's IPC Clinical Nurse Specialist to audit practices relating to infection

control guidelines. Gaps or deficits identified to be addressed through a QIPs in each area for an individual designated staff member with a particular focus on existing decontamination practices and cleaning schedule for each of the units – Completion target date 30/09/24

• One bedpan washer which was not working order on day of inspection was decommissioned and awaiting a planned service. This bedpan washer is currently operational and in use – Completion date 10/06/2024

• Review and enhance the current maintenance oversight practices within the centre to ensure timely report and service traceability of equipment at individual unit level. This oversight to include a feedback loopback at individual unit manager level - Completion target date 31/11/24.

• The Centre's 2024 Annual Review to be reviewed and updated to reflect quality and safety of care analysis aimed at identifying deficits to inform the improvement plan and actions for the following year - Completion target date 31/01/25

Regulation 24: Contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

• A review of all residents files to ensure a contract of care is in place which reflects the residents room number, type of room and occupancy (single/double/multi occupancy) and the weekly NHSS client contribution charges– completion target date 31/09/24

• Quarterly audit of contracts of care completed by the designated centre's individual unit managers (CNMII) with amendments documented in contract of care -Completion target date 01/10/2024

• Contract of care updates will be inserted as a line item of the agenda at the CNM2 monthly meetings- Completion date 24/06/2024

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:

• Designated Centre's statement of purpose updated immediately post inspection to reflect staff complement reflects that the designated centre's management personnel have no link to the disability unit on campus- Completion date 10/06/2024

• Statement of purpose updated to reflect arrangements in place that documents senior management support at individual unit level - Completion date 10/06/2024

• Documented overview of the facilities (laundry, administration building and archives) necessary to support the centre. This is supported by revised Floor Plans reflecting identified support buildings- Completion date 24/07/2024

Regulation 30: Volunteers	Not Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:

• Development and implementation of COH Volunteer policy capturing roles and arrangements for supervision and vetting disclosure in line with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 – Completion target date 02/09/24

Regulation 31: Notification of incidents	Not Compliant

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

• One of the safeguarding notifications in relation to the two incidents identified by the inspectors on day of inspection was submitted to the office of the Chief Inspector on the 15/02/2024 and closed out. The second incident was a complaint by a family which was investigated and addressed at the time. This incident's notification had been submitted retrospectively to the office of the Chief Inspector at their request – Completion date 07/06/2024

• Develop and implement a standardised feedback loop to ensure learnings are applied following incidents/complaints outcomes are reviewed at the designated centre individual unit level – Completion target date 27/09/24

• Staff informed at the designated centre's Quality and Patient Safety meetings 15/6/2024 by the Person In Charge (PIC) of the importance of timely reporting of the perceived safeguarding concerns for all stages of the management process to the office of Chief Inspector–Completion date 15/6/2024

• A review submission of notifications will be carried out by the PIC on a quarterly basis to review compliance. Audit report reviewed at the Centre's Quality and Patient Safety meeting –Completion target date 1/10/2024

• Nurse management team to complete quarterly trend analysis on incidents/complaints to enhance timely reporting on identified patterns of risk in each of the individual units within the designated centre. Finding to be reported at the Quarterly report reviewed at the Centre's Quality and Patient Safety meetings– Completion target date 1/10/2024

• Monthly meeting between individual unit managers (CNMII) and nurse management to promote shared learnings and timely notification on incidents – Completion target date 1/10/2024

CNM2s report on share learnings from incident management outcomes at monthly Quality and Patient Safety meetings – Completion date 15/07/2024

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

• A review of the centre's local policies has been completed to ensure they only reflect the needs of older people living in the designated centre-Completion date 17/6/2024

• Monitoring and Documentation of Nutritional Intake Policy updated –Completion date 10/06/2024

• The Designated centre's Records Policy is being developed in line with the HSE National Records Retention Policy and HSE standards and recommended practices for healthcare records management – Completion date 30/09/2024

• Residents Personal Property, Personal Finances and Possessions Policy to be updated to reflect the latest national policies and guidelines – Completion date 30/09/2024

• Develop Clinical Governance Policy for Cherry Orchard to provide greater oversight of the local management processes – Completion date 30/09/24

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• Review current contract for outside spaces with the HSE maintenance department with the aim of improving the ongoing maintenance of the outside garden spaces for each individual unit - Completion date 31/08/24

• Audit the cleanliness and upkeep of the outside spaces and gardens pertaining to the older person designated centre and develop a QIP for service improvements- Completion date 31/12/24

• The commencement of permanent flooring works in Sycamore and Willow units is planned once all current residents have been relocated and furniture removed on from these units 31/09/2024 - Completion target date 31/03/2026

• Insert call bells in the Family/Palliative Care room and Snoozelen room in Aspen- Completion date 24/06/2024

• Ongoing monitoring of improvement of the ventilation deficit (assisted toilet and dirty utility room) in the Beech Unit will be achieved by checking that the ventilation system is turned on as part of the daily morning service walk around performed by the individual unit manager – Completion date 31/05/2024

• The flooring in the assisted toilet in Beech unit will be replaced- Completion target date 30/03/2025.

• One bedpan washer was not working on the day of inspection. This was already decommissioned and awaiting a planned service. This is now complete and the bedpan washer is currently working and in use- Completion date 10/06/2024

• Review and enhance the current maintenance oversight practices within the centre to ensure timely report and service traceability of equipment at individual unit level. This oversight to include a feedback loopback at individual unit manager level - Completion target date 31/11/24.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:

• Designated Centre's directory for residents updated to strengthen existing terms and conditions. A particular focus on ensuring information relating to residents in the centre; complaint; personal property and finance processes are clearly outlined in line with relevant HSE guidelines and regulations – Completion date 31/09/24

Regulation 27: Infection control	Not Compliant

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

• Designated Centre's IPC Clinical Nurse Specialist to audit practices relating to infection control guidelines. Gaps or deficits identified to be addressed through QIPs in each area for an individual designated staff member with a particular focus on existing decontamination practices and cleaning schedule for each of the units. – Completion date 31/09/24

• Designated Centre's IPC Clinical Nurse Specialist to provide oversight for the delivery of the QIPs in relation to the identified deficit areas-Completion date 01/10/2024

• Household manager to provide oversight for the delivery of the QIPs in relation to cleaning- Completion date 10/06/2024

• Household Manager to review cleaning schedules for Sycamore and Willow units while residents remain with a specific focus on the kitchen and Snoozelan room and laundry trollies – Completion date 22/06/2024

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• Develop and implement a plan to strengthen the existing management processes for the storage of medicinal products in each of the individual units within the designated centre. A particular focus on ensuring prescription for nutritional supplements; timely disposal of supplements no longer required in line with legislation requirements –

Completion target date 31/10/24

• Removal of inappropriate nutritional supplements storage in centre's pantry areas (Beech and Aspen Unit)- Completion date 28/07/2024

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• Care Plan audit in relation to responsive behaviors to be completed by individual unit managers (CNMII) with a particular focus on applying person-centered techniques to support individual residents to navigate their behaviors Completion date 1/10/2024.

• Responsive Behavior Training updates to be delivered to all staff - Completion target date 31/12/24

• Visitor room (Beech unit) open access provision with signage in place to remind staff to maintain this as an open environment. Access checked as part of the daily service checks by the individual unit manager- Completion date 10/06/2024

• Staff training around new lock doors system giving access to the gardens in the Aspen and Beech unit rolled out – Completion target date 2/10/24.

• The designated centre's mutidiciplinary team convened a meeting to review the behavioural care plan for the individual resident in the Aspen unit whose access to the bathroom posed a risk. Based on this review the decision was to remove the coded lock on the door handle for the two assisted toilets and a shower to ensure full restraint-free environment. Completion date 2/07/2024

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• Designated centre will review the Pension Agent arrangement process onsite to ensure relevant resident's finances are protected. The Registered Provider will provide regular updates on the review to the Regulator- Completion date 31/12/24

• A nominated member of the designated centre will directly support engagement with residents where HSE is the pension agent on a bi-monthly basis or more frequently if required to enable and support residents to make informed choices to utilise their finances to enhance their residential care experience based on their personal preferences. This includes:
· Providing a breakdown on what finances are available to them and how this can be accessed
· Exploring spending options based on personal interests/preferences e.g. sourcing cinema/concert ticket etc.
· Develop and document individual person-centred social care plans utilising available funds to enhance the quality of their care
· Timely follow up on any individual queries
This engagement will be supported by the individual units Clinical Nurse Managers and Social Workers - Completion target date 31/12/24

• Designated centre will keep a copy of signed completed Pension Agent application forms - Completion date 14/10/2024

• Designated centre will follow up with families of relevant residents who have died regarding financial arrangements - Completion date 4/06/24

• PIC to develop and implement a standard operating procedure to enhance the designated centre's management team governance oversight around individual complaints/safeguarding/incident management. This is to ensure timely responses to any identified concerns - Completion target date 1/10/2024

• Quarterly trend analysis completed on incidents/complaints/safeguarding reports by each individual unit CNMII and findings presented at the monthly the Quality and Patient Safety meeting to generate quality improvement plans and identify patterns of risk – Completion target date 31/9/2024

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• Currently the changes and consent for bed or room transfers is documented in resident's records. The service will now also keep a copy of all moves in the resident's contract of care. Contract of Care updates will be an agenda item at the CNMIIs monthly meeting – Completion date 8/07/2024

• All quarterly financial statements will be sent to the administration office in COH and a delegated member of staff will engage directly with individual residents to enable them to make informed choices regarding financial arrangements– Completion target date 31/12/2024

• All communal facilities to be reviewed to ensure access is not restricted. An open access sign placed on all communal facilities to remind staff to maintain open access and to orientate relatives to its usage. Access checked as part of the daily walk around checks by the individual unit managers- Completion date 10/06/2024

• Emergency call-bell chords accessible in the communal toilets in the Aspen unit – Completion date 24/06/2024

• Individual risk assessment and resident engagement to be completed where polycarbonate crockery usage is being considered for resident's with dementia or mobility issues- Completion date 19/08/2024

• Designated Centre's Catering manager introduced polycarbonate plastic bowls which have low heat conductivity properties and keeps food warm for longer to enhance the mealtime experience for residents with dementia or mobility issues who are slow to eat due to environmental distractions. Where this is introduced for individual residents it will be supported by a risk assessment and documented in individual care pan- Completion date 19/08/2024

• Residents' personal time preferences in relation to getting out of bed for breakfast will be documented in individual resident's care plans– Completion date 19/08/2024

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:

• Monthly quality care metric completed with Quality Improvement Plans with action plans developed and implemented by CNM2s on the units. This is monitored by our CNM2 in education- Completion date 27/06/2024

• All resident care plans are reviewed quarterly by the primary nurse. Completion date 27/06/2024

• Annual care plan audit completed for all residents' care plan to ensure processes are in line with HSE Policy's care planning- Completion date 27/06/2024

• To enhance governance oversight on care plans , quarterly audit of care plans completed by designated individual unit nurse managers (CNMII)- Completion date 24/11/2024

• One care plan identified on the day of inspection referenced COVID infection

management relating to 2022 incident removed – Completion date 10/06/2024

• One care plan identified on the day of inspection requiring crushed medication administration updated completed to reflect the current consistency of food and fluid requirements based on the most recent Speech and language therapy (SALT) assessment – Completion date 10/06/2024

• One nutritional care plan for the individual resident with a recent history of weight loss and receiving a nutritional supplement reviewed and updated- Completion date 10/06/2024

• Individual unit managers to provide a status update on individual resident's care plans at the centre's scheduled CNM meetings as well as the Quality Patient Safety review meetings. Action plans generated for any identified gaps– Completion target date 04/09/2024

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 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.	Not Compliant	Orange	30/03/2025
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	30/09/2024
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	30/09/2024
Regulation 21(1)	The registered provider shall ensure that the	Not Compliant	Orange	02/12/2024

	records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/07/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	24/07/2024
Regulation 23(b)	The registered provider shall 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.	Not Compliant	Orange	30/09/2024
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate,	Not Compliant	Orange	30/09/2024

	consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Not Compliant	Orange	31/12/2024
Regulation 23(e)	The registered provider shall ensure that the review referred to in subparagraph (d) is prepared in consultation with residents and their families.	Not Compliant	Orange	31/12/2024
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom,	Not Compliant	Orange	08/07/2024

	on which that resident shall reside in that centre.			
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Not Compliant	Orange	30/09/2024
Regulation 24(2)(c)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of where appropriate, the arrangements for the application for or receipt of financial support under the Nursing Homes Support Scheme, including the arrangements for the payment or refund of monies.	Not Compliant	Orange	30/09/2024
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	Not Compliant	Orange	01/10/2024

	implemented by staff.			
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a resident are stored securely at the centre.	Substantially Compliant	Yellow	28/05/2024
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Substantially Compliant	Yellow	31/10/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation or guidance in a manner that will	Substantially Compliant	Yellow	29/05/2024

	not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
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	10/06/2024
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	24/07/2024
Regulation 30(a)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre have their roles and responsibilities set out in writing.	Not Compliant	Orange	02/09/2024
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Not Compliant	Orange	02/09/2024
Regulation 30(c)	The person in charge shall ensure that people involved on a	Not Compliant	Orange	02/09/2024

	voluntary basis with the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.			
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	01/10/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	30/09/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2024
Regulation 5(4)	The person in charge shall	Substantially Compliant	Yellow	31/12/2024

	formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
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	02/07/2024
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.	Not Compliant	Orange	02/08/2024
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	31/07/2024

Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	01/10/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	19/08/2024
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Not Compliant	Orange	19/08/2024
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	31/12/2024