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:	St. Peter's Nursing Home
Name of provider:	Costern Unlimited Company
Address of centre:	Sea Road, Castlebellingham, Louth
Type of inspection:	Unannounced
Date of inspection:	23 June 2025
Centre ID:	OSV-0000122
Fieldwork ID:	MON-0047096

About the designated centre

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

St Peter's is a purpose built nursing home which was extended in recent years. It offers care to 69 residents, male and female over the age of 18 years. The centre provides long-term residential care, convalescent and respite care. They care for those with a diagnosis of dementia and an acquired brain injury. They cater for those of low, medium, high and maximum dependency. Their purpose is to provide care on an individualised, fair and in an equal way while involving the resident and their families. The centre has 63 single and three twin en-suite bedrooms. Included in this is a 20 bedded dementia care unit. The centre is situated within five minute's walk of the village of Castlebellingham where residents' can access a variety of amenities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	66

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 23 June 2025	09:00hrs to 16:45hrs	Sheila McKevitt	Lead

What residents told us and what inspectors observed

The inspector walked around the centre, observing practices and speaking more in-depth with nine residents and three relatives during this inspection. Residents described the centre as a good and safe place to live andsaid that their privacy and dignity was maintained.

Relatives spoken with raised some concerns they had. For example, they said the staffing levels were not always sufficient to meet the needs of residents in a timely manner. They said that this caused an increase in the number of falls that one resident was having and that the general care needs of residents were not being met. The relatives spoken with confirmed with the inspector that they had either brought their concerns to the attention of the newly appointed person in charge or had made an appointment to speak with them.

There were not enough staff on duty to meet the needs of residents, some of whom told the inspector that their call bells were not always answered promptly. The centre was short of two care staff on the morning of this inspection, due to unexpected leave. The inspector saw that this resulted in residents spending long periods of time unsupervised and un-engaged; some were seen asleep in chairs for most of the morning in two of the three sitting rooms. However, when these staff absences were filled in the afternoon, the impact was visible as residents were supervised and seen engaged in activities. The inspector observed a lively music session which was enjoyed by many residents.

The inspector observed some person-centred and discreet staff interventions during the inspection. Residents were observed being encouraged and facilitated to mobilise along the corridors, to and from the dining room. Staff confirmed that they had received safeguarding training and those spoken with had a good knowledge of how to safeguard residents. However, due to staff shortages, the inspector also observed examples of rushed, task-centred care focused on activities of daily living and which did not consistently uphold residents' rights. Some examples had already been highlighted by residents during residents' meetings, including concerns that residents were getting up and washed by the night staff, even when this was not residents' choice. Such institutional practices did not upheld residents' rights.

Residents were well-groomed and relatives spoken with said this was usually the case. However, one relative stated that the chiropodist did not come in to review residents frequently enough and therefore their relative's toenails were overgrown and not pleasant to view. When brought to the attention of the management team, the confirmed that chiropodist visited and reviewed the residents every three to four months and they would follow up on this issue.

Residents' rights were not always upheld. Residents said they were given choices in relation to food and drinks offered at each mealtime and the inspector observed this. They had access to fresh drinking water, a choice of hot and cold drinks

between and after their meals. They also had access to a variety of snacks. However, the mealtime service provided to residents with dementia did not uphold their rights in the same way as it did for other residents. The inspector observed a number of residents in the dementia unit having their lunch in the sitting room, eating from a small table. They were not offered the same dining experience as other residents.

Residents had access to daily newspapers, televisions, radios and internet services within the centre. Some residents were observed reading the daily newspapers provided. Residents told the inspectors that the activities provided on a daily basis were ad-hoc and although a varied activity schedule was made available to them each week it was not always implemented in practice. In the absence of planned activities, residents could not make informed choices in respect of what activities they would like to attend and look forward to.

The inspector observed house-keeping staff busy cleaning residents' bedrooms and communal areas. Residents told inspectors their bedrooms were cleaned most days, however one relative stated that the standard of cleanliness was not high and had deteriorated. The inspector was informed there was one house-keeping post vacant at the time of inspection. Records showed that no environmental audits had been completed in 2025.

The inspector observed that some areas of the centre were not well-maintained. These areas were brought to the attention of the management team who stated there was a plan to have the highlighted issues addressed. However, there was no concrete refurbishment plan in place for 2025 and therefore the inspector could not confirm what areas were going to be refurbished.

The inspector was informed that changes had been made to two rooms within the centre. The internal smoking room had been converted into a store room and a store room had been converted into an office. No external smoking area had been provided for the residents who smoked. Five residents were observed smoking in the internal courtyards, however these areas did not provide shelter or the required fire safety equipment to ensure residents' safety. 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 affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

The level of compliance in this centre had deteriorated since the last inspection in August 2024. There had been frequent changes to the person in charge which impacted on the overall stability of the governance and management arrangements and oversight in the designated centre. The Chief Inspector of Social Services had been notified of a change in the person-in-charge. This was the fifth change in

person-in-charge in this centre within this three year registration cycle which was due to end on 05 October 2025.

This was an unannounced inspection with a focus on safeguarding. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended).

Although all staff had not completed to enable them to care for residents with responsive behaviors safely.

The inspection found that the governance and management of the centre was poor. Notwithstanding the unannounced night time inspection that had been recently completed by a member of the senior management team and although bi-monthly clinical governance meetings were being held in the centre, the oversight of service was insufficient and did not identify areas for improvement. The established system for overseeing the standard and quality of care delivered to residents was not being maintained and had failed to ensure a good quality of care was being delivered to residents.This is evidenced in the findings on this inspection and further outlined under Regulation 23: Governance and management.

The centre was not well-resourced. There were staffing vacancies, some of which had been vacant for three months and remained unfilled.

Staff had access to training. Although all staff had not completed training to enable them to care for residents with responsive behaviors (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) safely.

Regulation 15: Staffing

Inspectors were not assured that the provider had the required numbers of staff available with the required skill-mix, having regard to the size and layout of the centre and the assessed needs of the residents. This was evidenced by:

- Two rostered care staff did not show up for work on the morning of the inspection. Those shifts were not filled by replacement staff until lunchtime, which impacted residents' care.
- There was a lack of supervision in some communal areas, which posed a safety risk to residents.
- There was inadequate staff available to meet the social needs of all residents.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff had access to mandatory training and had completed safeguarding training. All staff had not completed training in how to manage responsive behaviors. The documentation reviewed showed that 54% of staff had completed this training. There were two scheduled dates for further training in this area of care, one scheduled for late June and another for mid July 2025.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had failed to ensure that adequate resources were in place with regard to the needs of the current residents and the size and layout of the designated centre.

There was a lack of staffing resources, resulting in a lack of resident supervision and support. Staffing resources overall required review, to include, healthcare, activities and catering staff, as detailed under Regulation 15: Staffing.

The established quality assurance systems had not been implemented since the beginning of the year and consequently, they no longer ensured that the quality and safety of the service were effectively monitored. This had a potential to negatively impact residents' safety. For example:

- the planned schedule of audits for the first six months of 2025 had not been completed. This complete absence of clinical and operational oversight meant that the provider failed to identify areas of service that required improvement.
- the quality of the ad-hoc audits completed to date in 2025 was very poor. For example a call-bell audit carried out in May 2025 consisted of one call-bell being rang as a representative sample. Records showed that it rang for over five minutes, prior to being answered. The audit had no action plan and there was no evidence that any corrective action had been taken by the management team.

The annual review completed for 2024 included a quality improvement plan, however the plan did not include a plan for improvement of the environment. Some areas of the internal and external environment were noted to be in a poor state of repair, for example, the internal courtyards were not well-maintained and the floor covering in one occupied bedroom was in a poor state of repair. There was no evidence that an environmental audit of the centre had been carried out to date in 2025, despite the centre having made an application to renew its registration for another three years.

Key issues of concern raised by residents at resident meetings and detailed under Regulation 9: Residents' rights had not being actioned by the management team.

Judgment: Not compliant

Quality and safety

The inspector found that insufficient staffing levels and ineffective systems of governance and management impacted on the quality and safety of consistent person-centred care to residents. Consequently, improvements were required in relation to care delivery, with particular regard to residents' assessments and care plans and residents' rights. The premises also required upgrading and upkeep in a number of areas.

The inspector saw evidence that all staff had garda vetting in place prior to commencing employment in the centre. There was a safeguarding policy in place, which staff had a good knowledge of. Staff files reviewed contained all the required documents and this assured the inspector that residents were safeguarded through a robust human resources policy that was in-line with legislative requirements and implemented in practice.

There was a low level of restraint use within the centre. Residents who displayed responsive behaviours had care plans in place which reflected trigger factors, if identified, for individual residents and de-escalation techniques that staff could use to prevent the behaviour escalating.

Some areas inside and outside the centre were not well-maintained. These areas required repair to ensure and promote a safe and homely environment , as discussed under Regulation 17: Premises.

The inspector reviewed a sample of sample of resident care plans and spoke with staff regarding residents' care preferences. There was evidence that that they were completed within 48 hours of admission and reviewed at four month intervals. Communication care plans were in place and they were person-centred however, the safeguarding and social care plans were generic in content and did not reflect a person-centred approach to safe-guarding residents and upholding their rights.

There was access to advocacy services with contact details displayed in the centre. There were resident meetings to discuss key issues relating to the service provided, however these were not being addressed hence the residents voice and feedback was not being heard. Residents had access to activities on an ad-hoc basis. Further improvement was required as outlined under Regulation 9: Residents rights.

Regulation 10: Communication difficulties

There were adequate systems in place to allow residents to communicate freely. Care plans reflected personalised communication needs. Staff were knowledgeable and appropriate in their communication approach to residents.

Judgment: Compliant

Regulation 17: Premises

The registered provider did not ensure that the premises of the designated centre were appropriate to the needs of the residents and used in accordance with the registered statement of purpose.

- The internal smoking room had been decommissioned and there was now no suitable safe smoking area available to residents. A number of residents were observed smoking in an area that was not appropriately sheltered and fully equipped to meet the needs of the residents.
- The provider did not communicate in advance to the Chief inspector as required by the condition of registration, the changes made to the purpose of designated spaces in the centre, such as the conversion of the smoking room to a store facility.

The following areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations:

- A number of residents' bedroom walls showed signs of wear and tear with unsightly markings and scuffs.
- The floor covering in a number of areas was ripped and tapped over including the flooring of occupied bedrooms.
- A number of corridor walls and wooden skirting and door surrounds were in need of repair.
- The enclosed gardens appeared unkept.
- The internal smoking room had been decommissioned and there was now no suitable safe smoking area available to residents.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The inspector reviewed a sample of comprehensive assessments, risk assessments and care plans in place for residents. Improvements were required to ensure that all

residents were receiving person-centred care informed by individualised care plans . For example:

- Some care plans were repetitive and did not give sufficient insight into the care the resident required. For example, safeguarding care plans reviewed consisted of a generic sentence that appeared to be copied and pasted from one safeguarding care plan into another. They provided no information on the specific needs and interventions required to safeguard the resident.
- Some social care plans were seen to be generic in nature. For example, an activity care plan stated that the resident had a right to engage in activities, but no further details was recorded regarding preferences or dislikes.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The designated centre's policy was available for review. There were appropriate and detailed care plans in place reflected the residents' individual needs, known triggers and known de-escalation techniques. The use of restraint was minimal.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place. Staff had completed safeguarding training and were aware of what to do if they suspected any form of abuse. Any incidents that had occurred in the centre were appropriately investigated and all residents reported that they felt safe and secure in the centre.

The processes for management of residents' finances were robust and reflected the centre's policy.

Judgment: Compliant

Regulation 9: Residents' rights

Based on observation and feedback from residents and relatives, action was required in relation to supporting residents' rights to meaningful occupation and social engagement.

- Notwithstanding the afternoon music session, there were limited meaningful

activities on the day of inspection. Many residents were observed sitting in the centre's communal rooms or in their bedrooms for long periods of time with little else to do. Staff interaction was observed to be predominantly task-oriented, centred around activities of daily living and lacked meaningful and stimulating engagement.

- Residents living with dementia did not have access to and therefore could not engage or participate in meaningful opportunities in accordance to their assessed needs, interests and capacities. For example, there were just two activities that had a dementia-care focus on the activity schedule in the unit where 19 residents were living with dementia.
- The schedule of activities displayed in the centre was not implemented. This meant that residents could not plan for how they liked to spend the day.

Although residents' meetings were being held and their views sought, they were not being actioned. For example, at the last residents meeting held in May 2025, it was highlighted that call-bells were ringing for a long time and one resident expressed concern that they had been woken at 5 am to be washed and dressed. There was no evidence that any actions had been taken to address these key concerns highlighted by residents.

The choice in relation to access to the dining room was restricted. For example, residents in the dementia unit were served lunch in the sitting room within this unit. These residents did not have the choice to access the same dining experience as other residents.

Judgment: Not 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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. Peter's Nursing Home OSV-0000122

Inspection ID: MON-0047096

Date of inspection: 23/06/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The center completes staff rosters two weeks in advance to ensure adequate staffing levels across all units and departments. A number of staff are available as bank staff to cover short-notice absences. In the event of staffing shortages, internal off duty staff are contacted first, followed by external agencies to provide additional support as needed. With support of HR we have developed a preferred pannel of agencies that are available to cover any shortage. • A supervision plan has been introduced to ensure communal areas are adequately monitored. • The activities schedule has been reviewed and updated to include meaningful and engaging activities for residents. • Additionally, a full-time Activities Coordinator has been recruited. The center will provide activities seven days a week to meet the social needs of all residents.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Director of Nursing (PIC) and Assistant Director of Nursing (ADON) will ensure that staff attend training as scheduled to reach compliance. • They will review training compliance monthly and liaise with HR to arrange additional sessions as needed until all staff have completed the required training.	

Regulation 23: Governance and management	Not Compliant

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

• The audit schedule has been reviewed and the Person in Charge (PIC) will ensure all audits are completed. Action plans are now being documented and followed up appropriately.

• The operations manager will continue to review clinical key performance indicators (KPIs) on a fortnightly basis. Any resulting action plans will be actioned by the PIC for implementation.

• The operations manager will also monitor the completion of all audits and associated action plans to ensure ongoing compliance.

• The call bell audit has been moved from an ad-hoc schedule to a monthly audit. The PIC is reviewing these audits to ensure that response times are within acceptable standards. Any issues identified will be addressed promptly through an improvement plan.

• An education session has been delivered to the staff responsible for completing audits and implementing action plans, to ensure clarity in expectations and consistency in documentation.

• The annual review for 2024 has been updated to include an environmental improvement plan, aligned with the existing maintenance plan.

• A comprehensive environmental audit was completed, and contractors have been scheduled to carry out required works.

• The PIC has met with the contractor responsible for courtyard maintenance, and a plan has been agreed to ensure regular trimming of plants and trees, as well as weed removal.

• The bedroom flooring that was identified as being in poor condition was replaced on 24th June 2025.

Regulation 17: Premises	Not Compliant

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

• The internal smoking room has been maintained until such time as a suitable alternative area has been located and equipped appropriately with a call bell, bench and fire extinguishers . When this has been completed a notification to vary the centre's statement of purpose to reflect these changes.

• The 2025 maintenance plan includes essential repair and refurbishment works throughout the centre. This includes painting and upgrades to bedrooms, corridors, and communal areas, where signs of wear and tear were noted, including scuffed walls, damaged wooden skirting, and general deterioration.

• The flooring in a resident's bedroom, which was identified during the inspection as being in poor condition, was replaced on 24th June 2025, as communicated to the Inspector on the day. • Further flooring replacements are planned, and appointments with contractors have already been arranged to complete these works. • The contractor responsible for garden maintenance has been engaged. A schedule is now in place for regular outdoor cleaning, pruning of trees and plants, and planting of flowers in the enclosed and external garden areas to ensure a safe, pleasant, and accessible outdoor environment for residents.

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: • Safeguarding care plans have been reviewed and personalised for each resident to reflect specific information and the required interventions needed to ensure their safety and well-being. • Social care plans have also been reviewed and updated in line with each resident's activities assessment and activity plan. These documents detail the resident's wishes, preferences, and interests regarding activities and form part of the mandatory assessment process. • Each resident has an individualised activities assessment and activity plan in place. All staff have access to this information through the Epic Touch system to ensure consistency in care and support.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The activities schedule has been reviewed and updated to include meaningful activities tailored to residents' individual needs and in consultation with residents' preferences. The schedule is prepared in advance and approved by the Person in Charge (PIC) before being disseminated throughout the center. • In addition to the in-house activity staff, there is also external entertainers booked in advance based on residents' preferences, and their visits are reflected in the activities calendar. • The activities coordinator is currently developing a dedicated activities schedule specifically for the dementia units, ensuring that all planned activities are appropriate and responsive to the unique needs of those residents.

• The PIC will ensure that all displayed activity schedules align with residents' social needs, promote meaningful engagement, and are implemented as planned, enabling residents to plan their day accordingly.
• A second full-time activities coordinator has been appointed. The center will now have two full-time activity coordinators, ensuring that meaningful activities are delivered seven days a week to meet the social needs of all residents.

Call Bell Response and Staff Engagement
• Staff meetings were held on 26th, 27th, and 30th June 2025, led by the regional operations manager, with attendance from staff across all units and shifts. Amongst other topics, the meetings focused on the importance of responding promptly to call bells and ensuring that all interactions with residents are meaningful and stimulating.
• To enhance monitoring, the Call Bell Audit has been moved to the monthly audit schedule. An educational session was held for the staff responsible for developing action plans based on audit findings. Following this, a formal action plan was implemented to address any identified issues and improve overall responsiveness and resident engagement.
• A Residents' meeting was held on 7th July 2025, and residents were encouraged to bring up any concerns. The meeting minutes and action plan have been completed.

• The Regional Operation Manager has had a meeting met the resident who raised concerns at the last residents' meeting, who gas expressed no further concerns.
• An educational session was held with the staff to ensure documenting the action taken after the meeting, and an action plan was put in place.

• The dining experience was reviewed on the Dementia Unit, and following the findings, an action plan was put in place. Furthermore, all residents have access to the dining room, and they can enjoy the dining experience.

• The PIC also completes visits to the dining room at meal times lunchtime to ensure that residents have a pleasant dining experience.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/08/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/11/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of	Not Compliant	Orange	25/07/2025

	purpose prepared under Regulation 3.			
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	15/11/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2025
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Substantially Compliant	Yellow	30/09/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a	Substantially Compliant	Yellow	30/08/2025

	person who intends to be a resident immediately before or on the person's admission to a designated centre.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	30/09/2025
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	30/09/2025
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	30/09/2025