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:	06 March 2025
Centre ID:	OSV-0000508
Fieldwork ID:	MON-0044499

About the designated centre

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

This centre comprises of 130 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 five units- The Beech, Aspen, Hazel, 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:	43

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 6 March 2025	08:00hrs to 17:50hrs	Geraldine Flannery	Lead
Thursday 6 March 2025	08:00hrs to 17:50hrs	Laurena Guinan	Support
Thursday 6 March 2025	08:00hrs to 17:50hrs	Manuela Cristea	Support

What residents told us and what inspectors observed

Inspectors found that residents in the centre were supported and encouraged to have a good quality of life. Residents expressed high levels of satisfaction with the care provided to them.

This inspection found that the registered provider had made positive changes in response to the previous inspection and ultimately demonstrated improved regulatory compliance with the regulations. Notwithstanding the improvements made by the provider since the last inspection, further action was required to be fully compliant and will be discussed further in the report.

Cherry Orchard Hospital residential facility, comprised of five units. Sycamore and Willow units were temporarily closed due to undergoing a programme of works to address issues relating to premises. Therefore this inspection focused on the three remaining units: Beech, Aspen and Hazel.

Overall, inspectors observed that the three units were clean and tidy and met residents' needs. They had been refurbished and redecorated and were seen to be bright and welcoming. Each was similar in layout and design, comprising of a single-storey building with bedrooms, residents' communal areas, family room, staff and ancillary areas. The entrance hallway in each unit had information for residents and visitors, such as the complaints procedure, fire evacuation procedures and the safeguarding statement. There was also a visitors' sign-in log; however, this was not well-maintained and in a consistent format throughout all the units.

Beech unit was colourfully decorated for the upcoming St Patrick's Day festivities. Bedroom accommodation was neat and organised, and many residents chose to personalise it with cushions, blankets and photographs, which gave the unit a homely atmosphere. The dining area had the menu on display and gave access to a secure courtyard with good seating and pathways so residents could safely enjoy the outdoors. Most residents were seen relaxing in the sitting room, with five staff engaging them in dedicated activities. The storage rooms on this unit, although clean and tidy, had an abundance of household and personal care stock, which reduced the amount of space available for safe storage of equipment, such as commodes and shower chairs. These were stored in the sluice room, and blocked access to the bedpan washer and sink. The family room did not have a call-bell, which posed a risk to residents using the room who may need assistance.

Aspen unit was seen to be attractively decorated, with many residents personalising their living spaces. Residents had just finished their lunch and were complimentary about the food offered to them. The dining room opened onto a large sitting room and also gave access to a secure outdoor area. The family room had two sofa beds to accommodate families who wished to stay when their relative was at end of life. The store and sluice rooms were clean and tidy. However, overstocking was also evident on this unit, again impacting on the safe storage of equipment. Access to

the sink in the sluice room was blocked by linen trolleys and a commode, which were being stored there. A hoist in the storage room had an out-of-order sign on it, but there was no date on the sign. Staff were unsure how long this had been broken, or when it had been reported and inspectors observed that maintenance records were not well-maintained and were difficult to follow up when an action had been completed. As an interim measure, staff in Aspen were borrowing the hoist from the Hazel unit, which added to the pressures on the staff in that unit.

Hazel unit was decorated with artwork and photographs, which created a pleasant environment. Residents were receiving hand massages from two staff in the open-plan dining/living area. A third staff member assisted a resident with artwork- while other residents worked independently. Music was playing on the TV, and there was a friendly, sociable atmosphere. Inspectors saw a large equipment storage room that was clean and tidy. While the equipment in this room appeared visibly clean, some had labels that identified them as being clean, while others did not. Staff reported that the equipment stored in that room had not yet been cleaned, which meant that the assistive hoists and wheelchairs were not ready to use. In addition, the labels, where present, were inconsistent with the signed cleaning checklists that were attached to the equipment, and the provider's own oversight systems had not identified this. This did not assure of effective infection prevention practice, and potentially posed a risk of cross-contamination.

Clinical rooms in all units were kept locked and clean, and medicine trolleys and presses in these rooms were also kept locked, which ensured the safe storage of medication. In the Beech and Hazel units, a prescribed fluid thickener was seen stored in an unlocked press in the kitchen, which was not in line with Regulation 29: Medicines and pharmaceutical services. The catering staff; however, were very knowledgeable about the safe preparation and use of the product.

There were several enclosed gardens on the campus. A smoking hut was viewed in one of the gardens, and it had a bin for cigarette butts. A fire blanket and fire extinguishers were located in close proximity. Residents who smoked had their own personal smoking apron, and they brought it with them when smoking. However, there was no call-bell available for residents' safety.

Residents in each unit were seen to receive visitors throughout the day. Visitors spoken with said that they were welcome at any time. They all praised the care, services and staff that supported their relatives in the centre, and they knew who to speak to should they have any concerns.

The person in charge confirmed that there was one open complaint on the day of the inspection. From a review of the documentation, it was evident that management was engaging in line with the process, and was striving to take on board learning from the various incidents and put measures in place to prevent further occurrences.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on 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

Overall, there was a clearly defined management structure in place, with identified lines of authority and accountability. During this inspection, inspectors reviewed the relevant actions from compliance plans from the most recent inspection dated 27 May 2024 and acknowledged that improvements had been made across most regulatory requirements. However, further improvements were required to ensure continued high quality care to the residents and will be discussed further in the report.

This was an unannounced inspection. 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 (as amended).

In addition, an application to vary condition 1 of the registration which was submitted to the Chief Inspector of Social Services prior to the inspection was also reviewed. The provider sought to increase the footprint of the centre to include; a social club, a physiotherapy office and gym for the residents and a music therapy room. The on-site laundry was due for a total upgrade, and the provider had an interim proposal for an alternative location to the laundry while works were on-going. The provider was requested to re-submit a revised copy of the statement of purpose (SOP), together with an updated floor plan (FP) that included all the proposed changes.

In preparing for this inspection, the inspectors reviewed the information provided by the provider and the person in charge and unsolicited information received by the Chief Inspector of Social Services.

The Health Service Executive (HSE) is the registered provider of Cherry Orchard Hospital. The person in charge had responsibility for the day-to-day operations of the centre and was supported in their role by a senior management team, including the general manager of older persons services and assistant directors of nursing (ADONs). Also in support were clinical nurse managers (CNMs), staff nurses, healthcare assistants, activity, catering, housekeeping, administrative and maintenance staff.

There was evidence of governance and management meetings. The quality and safety of care delivered to residents was monitored through a range of clinical and operational audits.

Throughout the day of inspection, staff were visible within the nursing home tending to residents' needs in a caring and respectful manner. Call-bells were answered without delay, and residents informed inspectors that they did not have to wait long

for staff to come to them.

Records reviewed were stored securely and made available for the inspection. However, some documents reviewed did not fully meet the legislative requirements, including written policies and procedures, contracts of care and visitors' log and will be discussed under the relevant regulations.

Records of complaints were available for review, and the inspectors reviewed a number of complaints received. Complaints were listened to and investigated, and complainants were informed of the outcome and given the right to appeal. Complaints were recorded in line with regulatory requirements.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application to vary a condition of registration had been received by the office of the Chief Inspector and was under review. Some discrepancies were noted between the statement of purpose and the floor plan, which required further review. In addition, not all registered areas were appropriately included in the floor plan submitted, and some further assurances were sought regarding the proposed new buildings to be registered.

Judgment: Substantially compliant

Regulation 15: Staffing

The inspectors reviewed a sample of staff duty rotas, and in conjunction with communication with residents and visitors, found that the number and skill-mix of staff were sufficient to meet the needs of residents, having regard to the size and layout of the centre. Staff had the required skills, competencies and experience to fulfil their roles and responsibilities.

Judgment: Compliant

Regulation 21: Records

Management of records was not fully in line with regulatory requirements, as follows;

- Not all records in relation to staff employment were available, as outlined in Schedule 2. For example, staff files did not include a contract of employment, therefore inspectors were unable to establish the date of role

commencement.

- The directory of visitors was not accurately maintained. Inspectors observed that the visitor log was undirected and disorganised with evident gaps, leading to inaccurate record-keeping. It was found to be in an inconsistent format throughout the units.
- There were gaps in documentation. For example, equipment temperature records or cleaning schedules were not accurately maintained to provide assurances in respect of the processes in place with regards to the management of equipment.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were sufficient staffing levels to ensure the safe delivery of care on a daily basis, the registered provider did not ensure that the allocation of staff resources was in line with its statement of purpose. Dedicated activity staff was not available at weekends to conduct weekend activities for residents, which meant that staff allocated to meet the healthcare needs were also tasked with the added task for the provision of meaningful activities and social care. This did not ensure that residents had consistent access to activities over the weekend, and there was no planned programme of activities that they could look forward to during that time.

Management systems in place on the day of the inspection were not sufficiently effective to ensure that the service delivered was consistently safe, appropriate and effectively monitored. For example;

- While environmental walkabouts and audits were carried out at regular intervals, they were not sufficiently robust to identify the risks and findings of this inspection, such as call-bells missing from communal and smoking areas.
- Information governance arrangements required strengthening as outlined under Regulation 21: Records, as the general oversight and supervision of maintenance logs and actions was inadequate and did not ensure that items that were reported broken or faulty were addressed in a timely manner. For example, residents and their visitors had restricted access to an enclosed garden in one of the units. The doors were locked due to a fault which had been reported. However, there was no timely action plan in place to address the issue. Also, maintenance records identified that a handle in a toilet on one of the units was broken, however the record was incomplete and did not provide assurance whether the handle had been fixed or since when.
- The assurance processes in respect of the management of equipment required stronger oversight. There was an inconsistent process in place to segregate clean from dirty and effectively identify clean equipment. For example, some equipment had labels that identified them as being clean, while others did not. Also, some 'I am clean labels' were contradictory to the cleaning checklist that was attached to the same equipment, some of which

had not been signed in months. Other gaps were seen in the daily checks of the temperature of the bed pan washer.

- There was insufficient oversight and supervision in the allocation of equipment resources, to ensure they met the needs of each resident in the centre. For example, one unit had no assistive hoist as it was broken, and it had to be shared with another unit where there were three hoists available. While there were storage facilities available in each unit, the management of supplies and storage arrangements required strengthening. For example; the overstocking of items reduced the amount of space needed for safe storage of equipment. Shower chairs and numerous linen skips were observed stored in the sluice room, blocking access to the bedpan washer and sink. Also, prescribed medication was stored unlocked, in the kitchen.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

Inspectors reviewed ten contracts for the provision of services. While inspectors noted significant improvements since the last inspection, there were gaps in two of these contract which did not include all the requirements of the regulation, for example;

- The occupancy of the bedroom in which a resident was residing was not clear. For example, single, double and triple occupancy were all ticked as relevant.
- The bedroom number in which the resident was residing was scored out multiple times, and therefore it was unclear which room was assigned to the resident.
- Another contract had not been signed by the resident and their representative, for a period of years.

Judgment: Substantially compliant

Regulation 30: Volunteers

The person in charge ensured that individuals involved in the nursing home on a voluntary basis had their roles and responsibilities set out in writing. They received supervision and support, and provided a vetting disclosure in accordance with the National Vetting Bureau.

Judgment: Compliant

Regulation 31: Notification of incidents

Notifications as required by the regulations were submitted to the office of the Chief Inspector of Social Services within the required time-frame.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display in a prominent position within the centre. The complaints policy and procedure identified the person to deal with the complaints and outlined the complaints process. It included a review process should the complainant be dissatisfied with the outcome of the complaints process.

Judgment: Compliant

Regulation 4: Written policies and procedures

While significant improvement was identified since the last inspection, further action was required to ensure all Schedule 5 policies were available, and updated to reflect legislation, for example:

- While there was a 'Garda vetting policy', there was no policy available on the 'Recruitment and selection of staff'.
- The policy on 'Resident's personal property, personal finances and finances', needed to be updated to reflect the actual practices in place.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors were assured that residents were receiving a high standard of care from a staff team who were familiar with their needs and preferences. A sample of six care plans across each of the units was seen to be person-centred, and validated assessment tools were used to inform care. Care plans were seen to

be updated four monthly and more frequently if required.

Residents had access to allied health professionals such as a General Practitioner (GP) and Tissue Viability Nurse (TVN). The professionals documented their assessment and advice in the resident's file, and this advice was incorporated into the resident's care plan. There was evidence that this advice was followed through in practice through nursing records and showed the trajectory, including the improvement in the resident's condition. For example, pressure wounds had fully healed following advice from the TVN.

There was appropriate assessment of and consent for restrictive practices that were in use. Evidence that the practices were monitored and reviewed regularly was shown to inspectors. Residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had person-centred care plans in place. Staff spoken with on the day outlined to the inspectors their knowledge of appropriate interventions to support residents with responsive behaviour.

There were arrangements in place to safeguard residents from abuse. A safeguarding policy detailed the roles and responsibilities and appropriate steps for staff to take should a safeguarding concern arise. The provider was a pension-agent for 11 residents, and a separate client account was in place to safeguard residents' finances.

Throughout the day, inspectors saw staff interacting with residents in a kind and respectful manner. A variety of one-to-one and group activities were seen taking place, and inspectors were told that a bus was available, which enabled trips to the local shopping centre, a nearby civic centre, and other places of interest. Residents could avail of many communal areas in the units, which gave them a choice of where to spend their time. However, the family room in the Beech Unit and some of the smoking huts did not have call-bells to alarm for assistance, if needed. This impacted on the residents' rights to access these areas safely and independently.

Regulation 11: Visits

Adequate arrangements were in place for residents to receive visitors, and there was no restriction on visiting. Visitors spoken with were complimentary of the care provided to their relatives and were happy with the visiting arrangements in place.

Judgment: Compliant

Regulation 27: Infection control

On the day of inspection, inspectors identified areas of good practice in the prevention and control of infection. Staff were observed to practise good hand hygiene techniques. All areas of the centre were observed to be very clean and tidy; however, quality assurance processes required strengthening, as discussed under Regulation 23: Governance and Management. Overall, procedures were consistent with the *National Standards for Infection Prevention and Control in Community Services (2018).*

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents had care plans that were person-centred, and reviewed and updated regularly.

Judgment: Compliant

Regulation 6: Health care

Residents had timely and regular access to health and social care professionals, and medical advice was documented and implemented in the resident's daily care.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The registered provider had a policy on 'Restrictive Procedures and Responsive Behaviour Guidelines' in place, which guided staff in practice. Staff were aware of how to appropriately manage and respond to responsive behaviours, and restrictive practices were used in accordance with National policy.

Judgment: Compliant

Regulation 8: Protection

All reasonable measures were in place to protect residents from abuse, including staff training and an up-to-date safeguarding policy.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors were not assured that residents' rights were being upheld at all times, as evidenced by the following;

- The absence of call-bells from communal spaces, impacted negatively on residents' ability and right to exercise choice and to seek help, if required.
- In the absence of allocated staff at the weekend dedicated for the provision of meaningful activities, residents had no programme of activities that they could look forward to, and the social programme was at the discretion of and dependent on the availability of staff on the day. This did not effectively support residents' right to exercise choice and consistently avail of opportunities to participate in activities in accordance with their interests and capacities.

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 7: Applications by registered providers for the variation or removal of conditions of registration	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cherry Orchard Hospital OSV-0000508

Inspection ID: MON-0044499

Date of inspection: 06/03/2025

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
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Substantially Compliant

Outline how you are going to come into compliance with Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration:

• Variances identified between the statement of purpose and the floor plans in a recently submitted application to vary conditions of registration to the office of Chief Inspector reviewed and rectified. Complete 10.03.2025

• A report generated by an external fire consultant submitted to the regulator provides assurance that the proposed new buildings - O'Deas Social Club, The Music Therapy room, The Physiotherapy room and the Interim Laundry area are all connected to the main hospital fire panel system. Complete 10.03.2025

• Reconfiguration of Rm 12 in Aspen unit has been amended as a shared room on the designated centre's statement of purpose in line with the recently submitted application to vary a condition of registration. Complete 10.03.2025

• An isolation emergency switch has been inserted beside the existing fire panel in the Interim Laundry area. Additionally the glass panel in this area, which had an open 'hatch' has been securely closed and partitioned. Complete 30.03.2025

• An external contractor has been sourced to implement an entire new call bell system on Beech unit along with additional call bells in the proposed new buildings (O Deas Social Club, physiotherapy room, music therapy room, communal areas on each unit) inclusive of designated smoking areas. Completion Target Date 12.05.2025

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Nurse management team reviewed and strengthen the designated centre's existing governance oversight of record management in line with regulatory 21 requirements. This generated the following action plan:

Ø Provider to complete an audit of the staff employment files to ensure all records in relation to employment as outlined in Schedule 2 are easily accessible in the Centre for regulatory inspection Completion Date 31.07.2025

Ø Centre's IPC CNS to initiate bi-annual audit schedule for residents' equipment. Completed 31.03.25 and ongoing thereafter

Ø Centre's IPC CNS to review and standardise existing clinical staff cleaning regime documentation across all units to provide reassurance management oversight processes are in place for equipment usage. Completed 31.03.25

Ø Bedpan washer temperature recordings to be included in the revised HCA cleaning documentation schedule Completed 31.03.2025

Ø Designated centre's visitors' directory log reviewed and updated, with a particular focus on addressing gaps identified on the date of inspection relating to standardizing directory formatting for all units operating across the centre, along with new GDPR compliant visitor book. Completion Date 21.04.2025

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Dedicated member of the nurse management team within the centre to review and strengthened governance oversight of resources. This generated the following audit schedule plan:
· Quarterly review of staff allocation to ensure alignment with the centre's statement of purpose Completed 31.03.2025 and ongoing review thereafter

· Quarterly assurance residents have consistent access to activities over the weekend through the implementation of a seven day planned programme of activities for each unit across the centre Completed 31.03.2025 and ongoing review thereafter
· a programme of works created with an external contractor to address identified call-bell deficits for communal and smoking areas. Completion 12.05.25

· Monthly operational call bell checks to be completed by individual unit CNMs. Completion 12.05.2025 and ongoing thereafter

· Quarterly review of maintenance logs to ensure that broken or faulty equipment are addressed in a timely manner and servicing of equipment is consistently safe, appropriate and effectively monitored; Completed 31.03.25 and ongoing thereafter

· Quarterly management review of supplies and storage arrangements for individual unit equipment and stock requirements. Completed 31.03.25 and ongoing thereafter

· HSE maintenance IT programme Tririga to be introduced across all units to standardise governance and oversight of maintenance management processes - maintenance logs, status updates on outstanding repairs and printable reports as required. Completion Date 30.06.2025

· All designated centre staff retrained in the management of the time lock open door access systems operating at individual unit level to allow garden access. This is reinforced by the development of a step-by-step guide for staff to facilitate changing access codes as required. Completed 5.04.2025

· Designated centre IPC CNS to review and strengthen the existing clinical staff (nursing and HCA) cleaning documentation to streamline reporting processes across all units to enhance existing practices. Completed 31.03.25

· Introduction of equipment management tracker to support timely maintenance reporting of faults and management of repairs across all the units. Completion Date 30.04.2025

· Individual unit CNMs removed excess stock from their units identified on day of inspection. Completed 6.03.2025

· Governance oversight of stock control levels added to CNM2 monthly health and safety walk-about checklist to promote compliance. Completed 31.03.2025

Regulation 24: Contract for the provision of services	Substantially Compliant

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

• Review and strengthen governance of the designated centre's contract of care with a particular focus on the agreements identified on the day of inspection requiring enhancements to address unsigned and room transfer gaps. Completion date 30/04/2025

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• 'Recruitment and selection of staff' policy to be developed for the centre Completion date 30.06.25

• Residents' personal finances policy updated highlighting the availability of comfort money for residents over a 7 day period supported by specific management and access guidelines. Completed 31.03.2025.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• An external contractor has been sourced to implement an entire new call bell system on Beech unit along with call bells in the proposed new buildings (O Deas Social Club, physiotherapy room, music therapy room, communal areas on each unit inclusive of designated smoking areas. Completion Target Date 12.05.2025

• Residents to have consistent access to activities over the weekend through the deliver of a seven day planned programme of activities for each unit across the centre Completion Date 31.03.2025 and ongoing thereafter

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
Registration Regulation 7 (3)	A registered provider must provide the chief inspector with any additional information the chief inspector reasonably requires in considering the application.	Substantially Compliant	Yellow	12/05/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	31/07/2025
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	Substantially Compliant	Yellow	31/03/2025

	the statement of purpose.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2025
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, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	30/04/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/06/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as	Substantially Compliant	Yellow	30/06/2025

	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.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/03/2025
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.	Substantially Compliant	Yellow	12/05/2025