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:	Sugarloaf Care Centre
Name of provider:	Spridale Limited
Address of centre:	Kilmacanogue South, Kilmacanogue, Wicklow
Type of inspection:	Unannounced
Date of inspection:	22 July 2025
Centre ID:	OSV-0008793
Fieldwork ID:	MON-0047761

About the designated centre

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

Located at the foot of the majestic Sugarloaf mountain in the village of Kilmacanogue, the Sugarloaf Care Centre can provide comprehensive care for 119 residents, accommodating both male and female residents. The centre can provide care for residents ages 18+. Each room is thoughtfully designed to create a warm and welcoming atmosphere. The units are named appropriate to its surroundings as follows : Lower Ground Floor is named Powerscourt accommodating 18 residents. 15 single en-suite, 1 single accessible en-suite and 1 twin en-suite. Ground Floor is divided into two units Glendalough and Mount Usher accommodating a total of 49 residents. Glendalough: 17 beds comprising of 15 single en-suite, 1 twin ensuite. Mount Usher: 32 beds comprising of 29 single en-suite, 3 single accessible en-suite First Floor is divided into two units Silver Strand and Laragh accommodating a total of 52 residents. Silver Strand: 17 beds comprising of 15 single en-suite, 1 twin ensuite Laragh: 35 beds comprising of 32 single en-suite, 3 single accessible en-suite. Sugarloaf Care Centre is designed to meet the health & social care needs and risk assessment of residents of all dependency levels. There are currently no limits or restrictions on the care needs the centre is intended to meet, and all prospective and current residents are assessed using a standard assessment, the Barthel Assessment Tool. Staffing levels are determined by the management of the centre having reviewed the resident's current dependency levels.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	87

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
Tuesday 22 July 2025	08:30hrs to 16:15hrs	Sarah Armstrong	Lead
Tuesday 22 July 2025	08:30hrs to 16:15hrs	Karen McMahon	Support

What residents told us and what inspectors observed

On arrival to the centre, the inspectors met with the person in charge. Following an introductory meeting, the person in charge accompanied the inspectors on a walk around the centre. This provided the inspectors with an opportunity to meet with residents and staff as they were preparing for the day.

Sugarloaf Care Centre is situated just outside the village of Kilmacanogue, with many bedrooms and communal areas offering views of the Sugarloaf mountain. Residents' accommodation is located over three floors and residents have unrestricted access to secure outdoor areas. The premises was thoughtfully laid out and well furnished throughout, however, some areas of the centre were found to be unclean with dust and debris. This is discussed in more detail later in the report.

There was a warm and welcoming atmosphere in the centre on the day of inspection and this was reflected in the feedback from residents, relatives and staff spoken with. Inspectors spoke with a number of residents on the day of inspection. All were positive about their lived experience in the centre and were full of praise for the staff. One resident told the inspectors "a highlight for me is that I can do what I want to do when I want to do it" whilst another resident told inspectors "we have such freedom here". Residents also expressed satisfaction with the range of activities on offer in the centre and told inspectors that the activity programme allowed them to participate in things that they had never experienced before, such as Tai Chi which they said they enjoyed. Another resident told the inspectors " I look at the list and decide what I want to go to and what I don't want to go to", adding that staff respected their choices. Inspectors observed residents taking part in different group and individual activities on the day of inspection which were found to be meaningful and appropriate to residents' individual capacities and capabilities.

Residents also spoke highly of the choice and quality of food in the centre. One resident told inspectors "the food is very good here". The inspectors observed the lunch time experience on all floors and found that there were enough staff on duty to support residents at meal times. Menus offered choices of main courses at each meal. Residents said that the portion sizes suited them and there was plenty of choice. Food was served from hot trolleys in the dining rooms and was cooked on-site daily. The food looked appetising, wholesome and nutritious. Tray service was available for residents who wished to take their meals in their bedrooms. Specialist diets were catered for and residents who needed textured meals were offered choices at each meal time. Inspectors also observed two instances of where residents had additional requests at meal times. One resident asked for extra sauce with their meal and another did not like the meal provided and requested an alternative. In both cases, staff were quick to respond to residents' requests and ensured their needs were catered for promptly.

All residents spoken with said they felt safe living in the centre and that staff respected their privacy. One resident told inspectors "staff always knock before

coming into my room". When asked about the complaints process in the centre, residents spoken with were aware of who to speak with should they have a concern. One resident told the inspectors that they had used the complaints policy previously and they were "very happy with how efficiently and thoroughly" their complaint was dealt with.

Residents' bedrooms were appropriately furnished and personalised to residents' own tastes and interests. Residents told inspectors that they liked their rooms. One resident told inspectors "I was really encouraged to bring as many things from home to make my room my own".

Inspectors also spoke with visitors on the day of inspection and again, feedback was positive. One relative told inspectors "I can't speak highly enough of the staff". Visitors also told the inspectors that the actions of staff were resident focused and were not task orientated, with residents requests attended to in a timely manner. One relative told inspectors that staff were keen to promote residents' independence as much as possible. For example, by supporting residents to use the toilet despite the fact that the resident wore incontinence wear.

Staff spoken with felt supported by the management team and told inspectors that they had good access to training appropriate to their roles. Staff felt that the care delivered to residents was unhurried and that staff had sufficient time to give to the residents. Another staff member told inspectors that they enjoyed working in Sugarloaf Care Centre as the staff, residents and relatives were "lovely people". Staff to staff and staff to resident interactions observed by inspectors on the day were respectful and cordial which supported a calm and pleasant environment within the nursing home.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being provided.

Capacity and capability

Overall, this inspection found that the centre was being managed for the benefit of the residents who lived there. However, some improvements were required to the oversight and management processes in place to ensure that the services provided to residents were safe, appropriate, consistent, and effectively monitored.

This was an unannounced inspection carried out by inspectors of social services over the course of one day. The purpose of the inspection was to monitor for compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the compliance plan from the previous inspection which was held in October 2024, statutory notifications that had been submitted to the Chief Inspector since the last

inspection, and unsolicited information received by the Chief Inspector since the last inspection.

The inspectors found that the compliance plan submitted by the provider had not been fully implemented at the time of this inspection. Although the provider had completed a number of actions and was working towards compliance with the regulations, there were some outstanding actions required, in particular, in respect of Regulation 27: Infection Control, Regulation 31: Notification of incidents and Regulation 23: Governance and management.

The provider of Sugarloaf Care Centre is Spridale Limited. The centre has a clearly defined management structure in place consisting of a registered provider representative, person in charge, assistant director of nursing and a clinical nurse manager. A dedicated team of staff nurses, health care assistants, activity co-ordinators, housekeeping staff, catering staff, maintenance staff and administration staff make up the remainder of the staff compliment.

The registered provider had maintained sufficient staffing levels within the centre, which took into consideration the skill mix of staff, the layout of the centre and residents' dependency levels. There was a robust induction programme in place for new staff in the centre. Staff told inspectors that this programme was a good support to them when they started in their roles. There was also a system in place to ensure annual staff appraisals were completed and, where required, inspectors saw evidence that performance improvement plans were put in place for staff to enable them to develop within their roles. Inspectors observed a number of interactions between staff and residents on the day of inspection, and found that staff had a good knowledge of the residents and their needs and preferences. Residents told the inspectors that they felt supported by a staff team who were responsive to their needs and respectful and kind towards them.

Staff had access to appropriate training suited to their roles. All staff had completed safeguarding training and staff spoken with were knowledgeable in identifying and responding to allegations of abuse. Residents spoken with told inspectors that they felt safe and secure living in the centre. Inspectors reviewed a sample of staff files. All records reviewed showed that staff had valid Garda vetting in place. There were some gaps in employment histories noted for two staff reviewed. This is discussed further under Regulation 21: Records.

The provider had a range of governance and oversight systems in place to monitor the quality of care and the standard of the service provided to residents living in the centre. However, there were aspects of the compliance plan from the previous inspection which had not been implemented in line with the time frames set out by the provider in respect of Regulations 27, 31 and 23. This is further discussed under the relevant regulations.

Regulation 15: Staffing

Staffing numbers and skill mix were sufficient to meet the assessed needs of residents in the designated centre. There was a registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training. There were records of regular supervision meetings and performance reviews being completed with staff, and where required, there were performance improvement plans in place.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had maintained a directory of residents which contained the required information specified in the regulations.

Judgment: Compliant

Regulation 21: Records

Inspectors reviewed a sample of three staff files and found that in the case of two staff members, there were gaps in their employment histories, and there was no record of a satisfactory history of those gaps as required under Schedule 2 of the Regulations.

In addition, inspectors also observed residents' nutritional records being stored in a manner which was unsafe, as they were displayed in two communal kitchenette areas which were accessible by other residents and visitors to the centre meaning residents' personal information was easily accessible to view.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management and oversight systems in place had not ensured that the service provided was safe, appropriate, consistent and effectively monitored. This was evidenced by the following findings;

There was insufficient oversight from management to ensure that;

- Residents were discharged from the centre in a manner that was planned and safe, and where residents were required to be transferred to hospital, that appropriate nursing transfer documentation accompanied them to the receiving hospital. This is set out further under Regulation 25: Temporary absence and discharge.
- The use of restraints was in line with national policy and the centre's own policy. This is discussed further under regulation 7: Managing behaviour that is challenging.
- All incidents notifiable to the Chief Inspector were notified in line with the required reporting time frames as set out under Regulation 31.
- The findings of an environmental audit completed in May 2025 had identified many issues which were identified by inspectors on the day of inspection as set out under Regulation 27: Infection control. Therefore, improvements were required to ensure that clear action plans were established in response to audit findings to address issues identified and prevent them from recurring.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors found that notification of incidents as set out in the regulations were not always submitted to the Chief Inspector within the required time frames of two working days. For example, in June 2025, an NF02 notification was submitted at 11 days, and an NF03 notification was submitted at 12 days. This is a repeat non compliance as per the previous inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had in place all policies and procedures as required by Schedule 5 of the regulations. Policies and procedures were made available to staff and had been reviewed and updated within the previous three years.

Judgment: Compliant

Quality and safety

Overall residents appeared happy living in the centre and their health, social care and spiritual needs were well catered for. Residents were well supported by staff and were able to choose how they spent their day. However, some improvements were required to ensure a safe and good quality service for residents, specifically in respect of restrictive practices and discharge or temporary absence practices.

The provider had made a number of improvements to the living environment for residents since the previous inspection. This included the addition of outdoor furniture for residents to sit and enjoy the secure outdoor spaces. Internally, the walls of the centre had been decorated to help residents orientate themselves within the centre. However, inspectors observed some areas of the centre which were visibly unclean and surfaces which were damaged and in need of repair in order to be effectively cleaned and to protect residents from the risk of infection. This is discussed further under Regulation 27: Infection control.

Residents provided positive feedback to inspectors regarding the food on offer in the centre and inspectors found that residents' nutritional and hydration needs were being met. Residents' nutritional status was assessed every month and health care professionals, such as general practitioners, speech and language therapists and dieticans, were consulted when required. Residents individual dietary requirements were clearly communicated to staff.

Residents were observed participating in a range of activities on the day of inspection which were meaningful and appropriate to their interests and capacities. Activity schedules were clearly visible for residents throughout the centre and there were dedicated staff available to support residents with their social and recreational needs. Residents also had access to TV, radio and newspapers to keep up to date with current affairs. There were regular residents' meetings held in the centre. Inspectors reviewed a sample of these meeting records and found that residents were supported to participate in the organisation of the centre. Residents also had access to independent advocacy services and information in respect of advocacy supports was maintained in prominent locations throughout the centre for residents.

Not all staff had accessed relevant training in responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). The inspectors' review of residents' documentation around restraint showed that significant action was required to ensure the use of restraint was being used appropriately and in line with the registered provider's own policy, which was aligned to national policy. This is further discussed under Regulation 7: Managing behaviour that is challenging.

A selection of care plans were reviewed on the day of inspection. Care plans were personalised and reviewed four monthly or sooner if required and reflected input from the resident or family where appropriate. However, the procedures in place for the pre-assessment and admission of residents did not provide assurance that they

adhered to the regulations as set out under Regulation 5: Individual assessment and care planning.

Regulation 18: Food and nutrition

All residents had access to fresh drinking water. Choice was offered at all mealtimes and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. The meals were served hot and in the consistency outlined in residents' individualised nutritional care plan. Residents' dietary needs were met. There was adequate supervision and assistance provided to those who required it at mealtimes. Regular drinks and snacks were provided throughout the day.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Inspectors reviewed a recent discharge in the centre and were not assured that the registered provider had processess for ensuring the safe temporary absence or discharge planning for residents was taking place, in line with their own discharge policy. This was evidenced by;

- There was no evidence of discharge planning or communication for a resident who was recently discharged. The agreement with the resident, and family, to discharge was not reflected in their documentation, as set out in their own resident transfer, discharge, and overnight leave policy. Records indicated that the resident had been transferred to a medical facility for medical assessment. However, the records did not indicate that the resident had been discharged from the centre due to the registered provider unable to meet their care needs. Inspectors were informed on the day of inspection that this was the reasoning for the residents discharge.
- Furthermore, appropriate nursing transfer documentation reflecting all relevant information regarding the resident was not sent to the receiving hospital.

Judgment: Not compliant

Regulation 27: Infection control

The provider did not ensure that infection prevention and control procedures were consistent with the national standards for infection prevention and control in community services published by the authority.

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

- Visible dust and debris on floors in corridors and in communal areas throughout the centre. In particular, a medical room on the lower ground floor had a significant build-up of dust along skirting boards, and there was a visible residue present within the clinical hand wash basin.
- Cobwebs with dead insects were observed in a number of areas including around the windows in a visitors room and in a residents' sitting room on the first floor. There was also evidence of insect droppings on window sills in these areas.
- The area behind the sink in the ground floor kitchenette did not have an appropriate back splash installed and therefore, the wall behind the sink was badly stained and had sustained water damage which was contributing to the development of black mould.
- Also within the kitchenette, the veneer was observed to be peeling away from the cupboard doors which meant that these surfaces could not be effectively cleaned.
- In the laundry, inspectors observed a bin left ready to collect clean clothes after a wash cycle. This bin was visibly dirty, with hair and other debris present. This did not ensure that residents would be protected from the risk of infection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While pre-admission assessment was taking place prior to a residents' admission to the centre, it was carried out by an external member of the registered provider entity who did not work full time in the centre. Inspectors were not assured that it was effective in ensuring the needs of the resident could be met in the designated centre which was evidenced by a recent unsafe discharge of a resident who's needs could not be met by the provider. On review of a pre-admission assessment it did not record pertinent information regarding the medical and social history for one resident which was essential to develop a personalised care plan to appropriately meet the care and social needs of that resident.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

While the registered provider had ensured all staff had access to training on managing behaviour that is challenging, only 58% of staff were up to date with this training on the day of inspection.

There was a high level of restraint use within the centre. A review of care planning arrangements and the registered provider's policy on restrictive practice, found that restraint was being used in breech of the centre's own and national policy. For example;

- There were multiple gaps in the five of the five restrictive practice risk assessment forms reviewed by inspectors, which did not identify if there had been a trial of least restrictive restraints or of relevant multi-disciplinary team input.
- While consent was signed, there was no evidence that the resident or their nominated representative, where appropriate, had been informed regarding the risks associated with the use of restraint, to make an informed decision when signing the consent form.
- Care plans directed that when bed rails were in use they were to be released every two hours. A review of two restraint release records for bed rails found that they were not maintained over a two day period in June 2025, when the bed rails would have been in use for these residents.

Judgment: Not compliant

Regulation 8: Protection

There was a safeguarding policy in place. Staff had completed safeguarding training and staff spoken with confirmed to the inspector that they had the appropriate skills and knowledge on how to respond to allegations or incidents of abuse.

The inspector reviewed the documentation in relation to safeguarding incidents that had occurred in the centre. The records showed that these incidents had been appropriately investigated and had relevant learning outcomes put in place.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Sugarloaf Care Centre OSV-0008793

Inspection ID: MON-0047761

Date of inspection: 22/07/2025

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: To ensure compliance the Registered Provider will have the following implemented and actioned as required • All staff files are under review and audits are being completed by RPR HR team to ensure all are compliant. Any future staff onboarding will have their file reviewed and signed off as compliant under schedule 2 by a member of the RPR HR team. All residents' records that were visible and displayed have been removed. All staff have been instructed to ensure no information is displayed openly in future.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: To ensure compliance the Registered Provider will have the following implemented and actioned as required: • To ensure all residents are discharged from the centre in a manner that is planned and safe, and where residents require to be transferred to hospital and that appropriate nursing transfer documentation accompany them to the receiving hospital, we have: updated our policy on discharge and transfer of a resident. • Training sessions have taken place with all nursing staff to ensure future compliance. • Appoint a CNM as transfer and discharge champion to track compliance and share audit outcomes with PIC/ADON. • Conduct post-discharge reviews to capture learnings from each case, this will be completed by our champion CNM. • A member of the RPR team reviews each transfer and discharge out of the centre to ensure all steps followed. • To ensure that the use of restraints is in line with national policy and the centre's own	

policy a full review has taken place with each resident that requires and uses a restraint. This has been reviewed by a member of the RPR clinical governance team to ensure compliance.
• Appoint a CNM as champion on Restrictive practice to track compliance and share monthly audit outcomes with PIC/ADON and PPIM.
• To ensure all incidents notifiable to the Chief Inspector are notified within the prescribed timeframe a member of the RPR clinical governace team reviews all incidents on the log and informs the PIC.
• To ensure all findings of any environmental auidit are actioned, a weekly meeting is taking place with our external cleaning provider to ensure any issues found are actioned as required. Further more an additional audit will take place monthly by a member of the RPR team to ensure ongoing compliance is maintained and issue do not recure.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required:
• To ensure all incidents notifiable to the Chief Inspector are notified within the prescribed timeframe a member of the RPR clinical governace team reviews all incidents on the log and informs the PIC.

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required:
• To ensure all residents are discharged from the centre in a manner that is planned and safe, and where residents require to be transferred to hospital and that appropriate nursing transfer documentation accompany them to the receiving hospital, we have: updated our policy on discharge and transfer of a resident.
• Training sessions have taken place with all nursing staff to ensure future compliance.
• Appoint a CNM as champion on Resident transfer/discharges to track compliance and share audit outcomes with PIC/ADON.
• Conduct post-discharge reviews to capture learnings from each case.
• A member of the RPR team reviews each transfer and discharge out of the centre to ensure all steps followed.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
To ensure compliance the Registered Provider will have the following implemented and actioned as required:
• To ensure that any visible dust, debris,cobwebs and dead insects on floors in corridors, in communal areas, skirting, window sills and ceilings throughout the centre is actioned a full review has taken place with our external cleaning contractors, all areas found by the inspectors have been addressed.
• The sink in the ground floor kitchenette will have an appropriate back splash installed and therefore, the wall behind the sink will not sustain water damage in future.
• The kitchenette in the ground floor,will have the veneer replaced to ensure that these surfaces can be effectively cleaned.
• All bins in the laundry have been cleaned and staff working within the laundry trained to ensure the area and all items within are clean and in order going forward thus reducing IPC risks.Signage in place and cleaning schedule in place.
• Implement a daily cleaning log with staff sign-off and CNM/ADON spot checks.
• Carry out monthly infection control walkabouts with the IPC lead.

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:
To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required :
• All preadmission assessments will be undertaken by a member of the senior nursing team as outlined in our statement of purpose for the centre. Our preadmission and admission policy has been updated to reflect this change. This will ensure that the care needs identified at the assessment can be met by the staff within the centre.

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:
To ensure compliance the Registered Provider and PIC will have the following implemented and actioned as required:
• Further training for staff has taken place on managing behaviours that is challenging and dates have been planned to ensure all staff within the centre are appropriatly trained. Newly onboarding staff will have this training offered to them within three months of commencing their roles.

• To ensure that the use of restraints is in line with national policy and the centre's own policy a full review has taken place with each resident that requires and uses a restraint. This has been reviewed by a member of the RPR clinical governance team to ensure compliance. All restrictive practice risk assessment forms have been reviewed by the clinical team within the centre and by memebers of the RPR governance team to ensure no gaps and that trials of the least restrictive restraint have been evidenced.These are then reviewed with our residents and their GP/Physio as required.The use of bedrails has significantly been reduced following the audit.
• All consent forms have been reviewed with the resident and or their nominated representative to ensure all risks are discussed and informed decision can be made.
• All care plans and restraint release records that direct that when bed rails are in use and when they are to be released example every two hours have been reviewed to ensure they are compliant. A member of the RPR does a sample review weekly and discusses the finding at the weekly clinical governace meeting with the PIC and ADONs.

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 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	31/10/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/10/2025
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	31/10/2025
Regulation 25(4)	A discharge shall be discussed, planned for and	Not Compliant	Orange	05/08/2025

	agreed with a resident and, where appropriate, with their family, and in accordance with the terms and conditions of the contract agreed in accordance with Regulation 24.			
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	05/08/2025
Regulation 25(3)	The person in charge shall ensure that, in so far as practicable, a resident is discharged from the designated centre concerned in a planned and safe manner.	Not Compliant	Orange	05/08/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards	Substantially Compliant	Yellow	30/11/2025

	published by the Authority are in place and are implemented by staff.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	18/09/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	18/09/2025
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 person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	18/09/2025
Regulation 7(1)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	31/10/2025

	have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
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	31/10/2025