Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Lakelodge Community Group Home
Name of provider:	Health Service Executive
Address of centre:	Sligo
Type of inspection:	Short Notice Announced
Date of inspection:	12 February 2025
Centre ID:	OSV-0001935
Fieldwork ID:	MON-0044464

About the designated centre

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

Lakelodge Community Group Home comprises a five bedroom bungalow located on the outskirts of a town in Co. Sligo. It provides full time residential care for up to four residents, both male and female, with an intellectual disability. Each resident has their own bedroom which is decorated in line with their wishes, and residents have access to a communal sitting-room and kitchen/dining room. The centre has a front and rear garden. Transport is provided. The centre is staffed by a team of care assistants and sleepover cover is provided at night time.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Wednesday 12 February 2025	10:30hrs to 17:00hrs	Úna McDermott	Lead

What residents told us and what inspectors observed

This was the first inspection of Lake Lodge Community Group Home (Lakelodge) since a change to a new provider in July 2024. The purpose of this inspection was to review the transition progress and to monitor and review the arrangements that the new provider had in place to ensure compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013)

The person in charge told the inspector that the changeover to the new provider was going well with some matters complete and some in progress. This was verified by the inspector through discussions with four residents, three staff and a review of the documentation provided. Overall, this was a good inspection where residents lived content and meaningful lives and their rights were respected. Some improvements were required to ensure that nursing staff were provided as identified by the provider. In addition, fire safety arrangements were under review by the provider and further work was required. These matters will be expanded on under Regulations 15 and Regulation 28 below.

This designated centre comprised a bungalow located on the outskirts of a busy town. The person in charge told the inspector that a review of the property was ongoing to ensure that it met with the needs of the residents living there as they aged. Some residents took the inspector on a tour of the building. It provided a welcoming home. It was personally decorated, cosy and bright. All residents invited the inspector to see their bedrooms. They were decorated in accordance with their wishes and had personal items displayed.

When asked, one resident told the inspector that they were happy in their home and that they had no reason to worry. They said that they liked who they lived with and they felt safe. Another resident told the inspector that they liked art and craft activities. They had a paper craft display model of the designated centre in their bedroom. They proudly showed the inspector the photographs of the residents which were in the windows of the model house. In addition, they had an advocacy poster on the wall. They spoke about their human rights and making their own choices when in their home. A third resident enjoyed spending time with animals and had photographs of dogs in their room. They smiled widely as they pointed to their favourite pictures. Staff told the inspector that the residents participated in dog therapy and that visits to the centre happened regularly. Throughout this time, residents were observed moving freely around their home, preparing for their day while chatting and laughing with staff.

This centre was a hive of activity that morning; however, there was a jovial and stress-free atmospheres. This was promoted by the staff team who spoke with the inspector about creating a calm homely environment where people's choices were respected and their rights upheld. All staff said that they completed training in human rights. Some spoke about the FREDA principles and supporting residents to

make informed decisions about their own lives while staying safe.

In summary, the change process was well managed in this designated centre and overall there was a good level of regulatory compliance. Residents spoken with said that they were happy and content and it was clear that they had active lives at their day services, meeting with family and friends and spending time in their community. Ongoing effort was required to ensure that staffing arrangements were in line with those identified by the provider. In addition, the strengthening of fire safety arrangements would further enhance the safety of the service provided.

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.

Capacity and capability

The inspector found that the provider and the person in charge had the capacity and capability to deliver a good service. Management systems were in place which ensured that the service provided was safe and appropriate to residents' needs. The provider had plans to improve their staffing capacity through the recruitment of nursing support for the service. Progression of this plan would further strengthen the service provided.

The person in charge was skilled and experienced and supported by the provider in their role. The centre had adequate resources. The property provided was well equipped and adequate transport was provided. While plans were in place to enhance the staff team, those employed at the time of inspection were experienced, trained and competent.

The person in charge had an audit schedule prepared for the year ahead. The information completed was reviewed and used to improve the service. In addition, incidents occurring were documented and evaluated in order to assess if risk management measures were required.

Overall, the capacity of the provider and the capability of the person in charge ensured that a good quality and safe service was provided. Examples of this are provided in the regulations below.

Regulation 14: Persons in charge

The person in charge remained the same during change to the new provider. This meant that a consistent leadership arrangement was in place during the transition

period.

- They were employed full-time and had the skills and knowledge necessary for the role.
- They had responsibility for one other designated centre which was located in the same town and said that they had the capacity to oversee both services effectively

Judgment: Compliant

Regulation 15: Staffing

The inspector was assured that there were a sufficient number of staff employed at centre on the day of inspection.

- Consistency of care and support was provided and there was a system to follow in case of emergency. This was evident as a staff member was unable to report for duty that day, and a familiar agency staff member was recruited to fill their place. However, this person was not available at short notice. The person in charge adapted the rota and a healthcare assistant agreed to compete additional hours in order to ensure that residents care needs were attended to.
- The inspector reviewed a sample planned and actual rota from 1 January 2025 to the date of inspection (12 February 2025). It was well presented, well maintained and provided an accurate reflection of the staff on duty on the day of inspection. For example, it included the changes referred to on the bullet point previous.
- Staffing at the centre was under review by the new provider. The review identified the need for nursing care in order to meet with the changing needs of the residents at the centre. For example:
- There was a 2.5 whole time equivalent (WTE) nursing vacancy. The provider had a recruitment campaign which was ongoing. While 28 hours nursing care was provided by a nurse from another service, ongoing work was required to fill the vacancies as identified by the provider.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider introduced a new training matrix to the service. The inspector found that it was populated correctly and contained information on the mandatory and refresher training modules completed and due.

- A review of the matrix found that all mandatory training from the sample viewed was up to date and the matrix was updated accordingly.
- In addition, all staff had completed training in a human rights approach in healthcare settings and as outlined in the opening section, they had a good awareness of the FREDA principles.
- The person in charge had a supervision schedule for 2025 which showed that a plan was in place for performance management meetings. All meetings were up to date.

Judgment: Compliant

Regulation 19: Directory of residents

The provider established a directory of residents in the centre which was maintained in line with the requirements of Schedule 3. The inspector reviewed 2 out of 4 directories and found the following:

- The information was up to date and most was transferred to the format of the new registered provider.
- Assessment of needs and associated care plans were available for review.
- Residents had comprehensive communication profiles and easy-to-read information on file if required.
- Arrangements were in place to ensure good oversight of resident's finances and valuables. Financial passports were signed by both the resident and their key staff member. Finance books logged credit and debit transactions. A check of six dates during January and February 2025 found that transactions were logged correctly.

Judgment: Compliant

Regulation 23: Governance and management

This was a well-managed service with appropriate local and senior management arrangements in place.

- As outlined, the person in charge was employed prior to the changeover to the new provider and their management systems. The provider had a buddy system in place which meant that the person in charge had support from a peer when required. They told the inspector that this worked very well.
- The person in charge had a good understanding of the systems and process used. Documentation reviewed on the day of inspection was maintained to high standard which meant that good oversight was maintained.
- The provider had an audit systems and a plan for the year ahead. A range of

weekly, monthly and quarterly audits were completed as required and information gathered was included on the centres quality improvement plan (QIP).

- The QIP was reviewed on 11 February 2025 and monthly thereafter by the person in charge. This was a shared document and was checked weekly by the staff team. Where actions were completed, they were closed off. Where actions were completed, but would take time and interim plan was put in place. For example, the provider planned to fit new floor covering to the property when the weather improved. The carpeted floor covering was steam cleaned in the interim.
- The annual review of care and support provided was not yet due. The six-monthly provider-led audit was due and pending completion. As per the regulation, this would be unannounced. While the person in charge was aware of a plan for its completion, they did not know when or by whom.
- A bespoke medicines audit was completed by the residents' pharmacist on the morning of the inspection. This reviewed the systems used to store, administer and return unused medicine to the pharmacy.
- The provider had a good understanding of the changing needs of the residents and they adapted the service in order to meet these needs. For example, the night duty staffing needs were under discussion at the time of inspection. Consideration was given to the need to change from a sleepover staffing arrangement to a waking night-time support in order to enhance the support shown to residents at night-time. This showed that the service was responsive to changing needs and to the management of risks.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had a statement of purpose which was up to date and in line with the requirements of Schedule 1 of the regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector completed a review of the incidents occurring in the centre from 01 August 2024 to the date of inspection (12 February 2025). This found that all notifiable matters were submitted for review by the Chief Inspector of Social Services in line with the requirements of this regulation.

Judgment: Compliant

Regulation 4: Written policies and procedures

The new provider had a range of written policies and procedures which were available for review at the centre.

- The inspector reviewed 20 policies under Schedule 5 and found that all were up to date with an exception as follows:
- The policy on abuse prevention was due for review in January 2025. The person in charge told the inspector that it was discussed at a service level person in charge meeting on 10 February 2025 and that an update was pending. An update on this was attached to the policy in the centre. This meant that clear guidance was provided for staff reviewing the same.

Judgment: Substantially compliant

Quality and safety

Resident's wellbeing and welfare was maintained by a good standard of evidence-based care and support provided by a dedicated staff team. While the inspector found that this was a safe service, ongoing enhancements to the fire prevention arrangements as identified by the provider would further enhance the safety of the service.

Residents living at Lakelodge told the inspector that they were happy in their home. The inspector found that this was supported by the person-centred approach to care which ensured that the voice of the residents was to the fore. Systems were in place which were effective in supporting residents healthcare needs. Opportunities for personal development were provided through both home and community activities. Risk assessment was an element of everyday life where risks identified were addressed promptly or added to an action plan. The property provided was clean and tidy and there was good adherence to the infection prevention and control measures in place.

Over all, the care and support was of good quality and ensured that people were safe. Examples of this are provided in the regulations below.

Regulation 26: Risk management procedures

The provider had systems and processes for the assessment and management of risk. There was a service and centre level safety statement, a centre level risk register and individual person-centred risk assessment for residents. The risk management policy was up to date.

- The provider had a primary risk screening process which was completed as part of the assessment of need. This provided a summary of risks which required control measures. A review of residents' risk assessments found that they were clear, comprehensive and reviewed regularly.
- Where required, the risks identified in positive behaviour support plans had corresponding risk assessment. This meant that proactive behaviour support strategies and risk control measures were consistent with each other and clear guidance for staff was provided.
- Emergency plans were available in the centre. This included a severe weather plan which was used in January 2025 during a nationwide red weather event. This plan was reported to work well. However, it was reviewed two days after the storm on 23 January and again on 24 January to ensure that additional learning was added to the plan in order to ensure its effectiveness for the future.

Judgment: Compliant

Regulation 27: Protection against infection

The provider ensured that residents who may be at risk of a healthcare associated infection (HCAI) were protected through the use of effective infection control policy and practice in the centre. For example:

- The provider had an infection prevention and control (IPC) contingency policy which was up to date and an outbreak contingency plan which was reviewed on 21 January 2025.
- Staff had up to date IPC training and were observed washing their hands at regular intervals during the ay.
- Residents were supported to understand the importance of infection prevention and control. They had access easy to read documentation which was noted around the centre. This included visual handwashing posters displayed close to the sink in the bathrooms. This meant that residents were supported to understand what to do to protect themselves. A resident was observed coughing on the morning of inspection and using the correct cough etiquette in order to protect themselves and others.
- A plentiful supply of soap and hand towels were available for use and bins were covered and in line with the standard required. The general upkeep of the house was to a high standard. It was clean and tidy throughout.
- Audits were completed on a regular basis and actions identified, if not already addressed, were on the centre's quality improvement plan. The most recent audit was completed by a clinical nurse specialist in infection prevention and

control on 7 October 2024.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had fire safety management systems in place including arrangements to detect, extinguish fires and to evacuate the premises.

- The fire prevention policy was up to date and all staff had fire training completed.
- Residents were provided with personal emergency evacuation plans which were reviewed on 11 February 2025. Staff employed were familiar with these, with the building and with the escape routes to follow if required.
- Fire drills were competed on a regular basis, and both daytime and night-time scenarios were used. Safety checks were taking place regularly and the information was recorded.
- Bespoke face to face fire training took place on 16 January 2025. All staff were provided with an opportunity to simulate evacuations using the new provider's guidance during this training.
- Where concerns were identified these were addressed promptly. For example, the inspector found that the door from the kitchen to the hallway was not closing fully. This was repaired and closing fully before the inspector left the premises.
- However, other work was required in order to reach full compliance as follows:
- While fire doors were provided, these were subject to a review and an upgrade as identified by the provider. Ongoing work was required to complete this action in order to strengthen the fire safety arrangements in place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

All residents had assessments of their health, personal and social care needs and associated person-centred plans. Some were in the process of transfer to the new provider's format but this task was progressing well and did not impact on the progressing of goals for the residents.

- All residents participated in planned activities such as sports activities in the local sports centre, knitting club and other community groups such as the 'Beo' club which took place on a weekly basis.

- Others enjoyed gardening, knitting and using laptops and electronic tablets to play games and listen to music.
- Where goals were set there was evidence that residents were actively involved in their progression. For example; one resident was planning a tea party with their friends. This was planned at a pace suitable to the resident. A date was set, invitations purchased and the guest list was being planned at the time of inspection.
- This meant that assessments and personal plans were competed in a collaborative way with the meaningful involvement of residents in line with their wishes and abilities

Judgment: Compliant

Regulation 6: Health care

The inspector was assured that appropriate healthcare was provided for each resident which regarded their assessed needs and their personal plans.

- Residents had access to a range of primary and consultant-led healthcare providers. Visits to clinicians were facilitated by the staff team and where recommendations were made, these were followed up on. Visits from allied health professionals to the residents' home were welcomed. For example;
- A resident was under the care of an advanced nurse practitioner who focused on health and wellbeing in intellectual disability. A referral to consultant-led care was made and a trip to the general practitioner (GP) for blood tests was required in the interim. The inspector found that there was no delay in the arrangement of these appointments. The resident had visited their GP with familiar staff support that morning and the tests were completed.
- In addition residents had access to services provided by clinical nurse specialists in positive behaviour support, brain health and tissue viability. All resident had bone health assessments completed.
- Furthermore, where the support of allied health professionals was required, this was provided. For example, residents had appointments with chiropody, dental care and audiology and home visits from occupational and speech and language therapy.
- This meant that this service had a proactive model of care delivery that was centred on the individual healthcare needs of the residents and where people worked together to ensure that a strong circle of healthcare support was provided.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required support with behaviours of concern, this was provided by specialists in positive behaviour support and behaviour support plans were in place.

- This approach was reported to work very well with a marked improvement in the wellbeing of one resident and a vast reduction in incidents of concern.
- Positive behaviour care plans were subject to regular review. For example, one plan was reviewed on 5 January 2025 and while it was in the process of updating to the new provider's format, there were signposts to follow if needed. This meant staff knew where to look for information and when found, it provided clear guidance.
- Positive behaviour support assessments were completed with one dated 19 November 2024. This recommended proactive strategies such as the use of visual communication tools for mealtimes were noticed in the kitchen and the resident's bedroom on the day of inspection. This meant that staff followed through on the recommendations of the professionals.
- There were no restrictive practices at this centre.
- Overall, the provider had good positive behaviour support practices in place in this centre. In addition, it was clear that where recommendations were made, corresponding risk assessments and plans of care were used to ensure consistency.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found a rights based focus in this designated centre. For example:

- A resident had an advocacy poster displayed on their bedroom wall. They showed this to the inspection and with the support of staff, they spoke about some of the FREDA principles and what they meant to them. They said that they liked to make their own choices.
- A resident also spoke about meeting with their advocate who assisted them during the change in provider for the service and remained in contact with them at the time of inspection.
- Another resident sat at the table with the inspector on their return from their day service. They had a cup of tea with the inspector and together with staff, they spoke about house meetings which were held weekly. They said that they discussed staying safe, making choices and having their voices heard.
- A review of residents' folders found that easy-to-read information was available which promoted their understanding of matters that were important to them such as bone health, diabetes and healthy eating. This assisted them to make decisions about their care and support.
- There were no restrictive practices in this designated centre which meant that residents had the freedom to move around and access all areas of their home

in accordance with their wishes.
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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lakelodge Community Group Home OSV-0001935

Inspection ID: MON-0044464

Date of inspection: 12/02/2025

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
To ensure compliance with Regulation 15 the following actions will be completed

• There is a regular HSE staff nurse working in the designated centre from 27/01/2025 who is knowledgeable in relation to the nursing assessments This staff nurse works an average of 28 hours within the centre weekly.
• This staff nurse provides clinical input/supports where required to service users.
• This nurse is involved in developing protocols and guidelines to support workers in the designated centre.
• A buddy system has been established with identified CNM2/PICs to offer guidance and support to PIC.
• The HSE's tissue viability nurse liaises with the PIC/staff nurse in developing SSkin bundles where applicable to service users and offers guidance in completing SSkin bundle assessments.
• There is support available from the clinical nurse specialist in Brain health and CNS in Behaviours of concern to offer support and guidance to staff in relation to behaviours of concern, positive behavioural support and brain health.
• There is an on-call out of hour's arrangement in place to support staff.
• All support staff are trained in the Safe Administration of Medications.
• An expression of interest for the 2.5 WTE staff nurse post was circulated by HR in September 2024 and reposted in February 2025.
• The service is currently running an additional Staff Nurse Recruitment campaign.
o This will be completed by 31/05/25.
• A risk assessment has been developed in relation to the 2.5 S/N vacancies within the service setting out the current controls in place to mitigate the risk.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
To ensure compliance with Regulation 4 the following actions are completed

• The Centre has implemented all Schedule 5 policies within the centre.

• The center has a copy of the Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures, 2014, which is signed by all staff working within the centre. This Policy is due for review nationally. Local SOP is currently under review to update to include new portal system.

• There are easy read leaflets available for residents on each policy, which is on display within the centre and discussed at residents meetings.

• The Sligo Leitrim Policy, Procedures Protocols Group meet monthly to review and update the Schedule 5 policies in accordance with best practise.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance with Regulation 28 the following actions will be completed

• The updgrade of fire safety equipment identified by the provider inclusive of ordering and commissioning of a new fire panel, and replacement of all fire doors will be completed by the 31/05/2025. This is on the centres quality improvement plan and is monitored regularly.
• All residents PEEPs were reviewed on the 11/02/2025 to reflect the inclusion of new bench purchased at fire assembly point. This was as a result of fire simulation training on 16/1/2025 where it was beneficial for service users to have an area to wait during safe evacuation.
• Going forward residents PEEP's and the centres CEEP will be reviewed should residents needs change.

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(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	31/05/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/05/2025
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with	Substantially Compliant	Yellow	15/02/2025

	best practice.			