



**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:	Dalkey Community Unit for Older Persons
Name of provider:	Health Service Executive
Address of centre:	Kilbegnet Close, Dalkey, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	04 March 2026
Centre ID:	OSV-0000510
Fieldwork ID:	MON-0049398

About the designated centre

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

The centre is based in South Dublin and is run by the Health Service Executive. The centre is close to bus routes no 29 and no 8 and to the dart service. It was purpose built in 2000 and provides 34 registered beds. There is also a day care service run on the same premises. The staff team includes nurses and healthcare assistants at all times, and access to a range of allied professionals such as physiotherapy and occupational therapy.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	33
--	----

I

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
Wednesday 4 March 2026	06:30hrs to 15:00hrs	Geraldine Flannery	Lead

What residents told us and what inspectors observed

This was an unannounced monitoring inspection, conducted with a focus on adult safeguarding and reviewing the measures the registered provider had in place to safeguard residents from all forms of abuse.

The inspector met with many residents during the inspection, and spoke with 11 residents in more detail, to elicit their experiences of life in Dalkey Community Unit for Older Persons.

Overall, residents said that they were supported to live comfortably in the centre and were adequately cared for by staff who were attentive to their needs for assistance. One resident stated that they felt 'safe living here'.

The inspector observed that the registered provider had made positive changes in response to the previous inspection to improve the delivery of services. For example, the inspector saw that appropriate equipment including emergency call bell and metal ash tray had been installed in the smoking shelter.

The centre is a two-storey building and residents are accommodated on the first floor which is divided into two units, Castle View and Hill View. The lived-in environment was warm and residents said they found it comfortable. The premises was generally clean, however some inappropriate storage was observed, which may pose a risk to effective cleaning. There were signs of general wear-and-tear in the centre, including scuffed doors and chipped paint on the walls of the corridors and in some bedrooms.

Bedroom accommodation comprised of both single and multi-occupancy bedrooms. Residents who spoke with the inspector were happy with their bedrooms and said that they had plenty of storage for their clothes and personal belongings. Many residents had pictures and photographs in their rooms and other personal items which gave the room a homely feel. One resident said that their room was cleaned every day and they were happy with that arrangement.

As previously identified in Hill View Unit, the layout of one of the bays in the two triple rooms would not allow sufficient space to accommodate a chair within the bed space. The inspector was informed that careful consideration of resident placement would be required, in consultation with the resident and their family.

On the morning of the inspection, the inspector found that improvements were required to ensure continued high quality care to the residents. For example, the clinical room and both sluice rooms were unlocked. This could lead to unauthorized access and cause harm in unsafe areas. The person in charge was informed and the rooms were immediately locked. The temperature in the clinic store room was extremely hot. There was a ventilation system in the room, however staff said they

keep it off during the night due to the room getting very cold. A prescribed fluid thickener was seen unsecured on the table in the dining room. Oxygen was being used by residents in two separate bedrooms, however there was no clear signage to identify the hazard. The person in charge was informed on the day of inspection and gave assurances that signage would be erected.

Lunchtime was observed to be a sociable and relaxed experience. Residents generally praised the food, describing it as 'good' and 'varied'. They confirmed that food and snacks were available at all times, including out-of hours. Residents appeared comfortable and were supported in a dignified manner during mealtimes.

Residents requiring modified diets were observed receiving meals in accordance with their assessed needs. Fluids were appropriately thickened as prescribed, in line with guidance from speech and language therapy (SLT). Residents were correctly positioned during mealtime to reduce the risk of aspiration and allowed adequate time for safe swallowing.

A schedule of activities was available, including group and individual options. The inspector observed very enthusiastic activity staff actively engaging with residents and residents said the activity staff were 'wonderful' but said 'they could do with more help'. Some residents said they enjoyed activities such as music and bingo, while others said that there were 'not enough things to do' particularly at the weekends.

A record of complaints was kept in the centre and appropriate action appeared to be taken to address any concerns. There was no open complaint at the time of inspection. Residents spoken with confirmed that they would not hesitate to speak with a staff member if they had any complaints or concerns.

Staff were observed to be respectful and responsive to residents' needs. Call bells were answered promptly during the inspection. Staff demonstrated appropriate knowledge of the residents.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that the management team were striving to improve practices and services. However, improvements were required in some areas specifically records, governance and management, individual care planning and

assessments, managing behaviour that is challenging, residents' rights and premises, and will be detailed further under the relevant sections of the report.

This was an unannounced inspection to monitor regulatory compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). This inspection had a specific focus on the provider's performance with respect to safeguarding vulnerable adults.

The Health Service Executive (HSE) is the registered provider for Dalkey Community Unit for Older Persons. The senior management team included the general manager for older person services and the person in charge. They were supported by clinical nurse managers, staff nurses, health care assistants, activity, catering, household and administration staff.

The provider had nominated a staff member to the role of designated Safeguarding Officer, with responsibility for safeguarding oversight, reporting and compliance.

Staff training records were maintained to assist with monitoring and tracking completion of mandatory and other training completed by staff. A review of training records indicated that the majority of staff were up-to-date with mandatory training, with a small amount of staff who were due updates booked into upcoming dates.

Records reviewed on the day of inspection were stored securely within the designated centre and made available for the inspection. However, due to insufficient storage, some resident records were stored in an off-site location and will be further discussed under Regulation 21: Records.

Regulation 15: Staffing

On the day of the inspection there were adequate staffing levels available to meet the needs of the residents, taking into consideration the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were facilitated to attend training relevant to their role. Staff demonstrated an appropriate awareness of their training and their role and responsibility in recognising and responding to allegations of abuse.

Judgment: Compliant

Regulation 21: Records

Management of records was not fully in line with regulatory requirements resulting in some Schedule 3 records not being readily available for inspection, as follows;

- Records to be kept in the designated centre in respect of each resident, were not retained in the designated centre for a period of not less than seven years.
- Records of residents who had ceased to reside in the designated centre, were not retained in the designated centre for a period of not less than seven years.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place required strengthening to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by the following:

- The general oversight of the physical environment and management systems required review, as outlined under Regulation 17; Premises, including greater oversight of security within the centre to keep residents safe. Controlled access to clinical area and sluice rooms was required to prevent misuse of medications, accidental ingestion of medications or hazardous substances, or injury from sharp objects.
- Effective information governance systems were not in place to ensure appropriate storage and availability of all records set out in Schedule 3 for a period of not less than seven years.
- The management oversight of residents' individual care needs and care plan documentation was not effective. A recent care plan audit had been completed, however it was not sufficiently robust to identify findings from this inspection. For example, recommendation of one care plan audit concluded that the care plan was comprehensive in nature; however the inspector found that the care plan did not outline known triggers and de-escalation techniques to guide staff in the delivery of safe care.

Judgment: Not compliant

Quality and safety

Overall, the service was aiming to deliver good quality care to the residents. However, further action was required to ensure ongoing quality and safety of the service as outlined under the relevant regulations.

The inspector reviewed a sample of resident care plans and spoke with staff regarding residents' care preferences. An electronic documentation system had been introduced in quarter four, 2025. A care plan audit tool had been developed and auditing had commenced the week before the inspection. However, the inspection found gaps in care planning that were not being picked up by the audit results. Staff informed the inspector that they had received care plan training, however said they would benefit from further training.

Residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had care plans in place, however some did not include the required level of detail to enable staff to provide an optimum level of care to the resident.

The provider had measures in place to protect residents from abuse including staff training and an up-to-date safeguarding policy. The inspector reviewed a sample of staff files and all files reviewed showed that staff had obtained Garda vetting prior to commencing employment.

Residents had access to a range of media, including newspapers, telephone and TV. There was access to advocacy with contact details displayed in the centre. There were resident meetings to discuss key issues relating to the service provided. However, improvement was required to support residents' recreational needs.

Observation of staff interaction identified that staff did know how to communicate respectfully and effectively with residents while promoting their independence. Staff were aware of the specialist communication needs of the residents and had an awareness of non-verbal cues and responded appropriately.

The premises was of suitable size to support the numbers and needs of residents. However, the management of the premises required improvement to ensure a safe environment for residents.

Since the last inspection, measures had been put in place to ensure that the dietary needs of all residents were met, including managing residents who had difficulty swallowing (dysphasia). Residents had an eating plan tailored to meet their specific health needs by altering food texture, consistency or nutritional content (modified diets). There was evidence of good communication between nursing staff, healthcare assistants and allied health professionals to ensure consistency in care.

Regulation 10: Communication difficulties

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

Judgment: Compliant

Regulation 17: Premises

The provider generally met the requirements of Regulation 17, however further action was required to be fully compliant as per Schedule 6 requirements. For example;

- Appropriate ventilation and heating were not in place in all areas of the designated centre. For example, the temperature in the clinical store room was not appropriate. There were no temperature records available for the room or the fridge that contained medicines. Labelling of some of the medications stated that storage was required at a temperature of maximum 25 degrees Celsius. This posed a risk that the efficacy of medicines stored in that room would be compromised.
- Due to insufficient storage in the centre, some records set out in Schedule 3 were not located in the centre for a period of not less than seven years.
- Areas in the centre were not secure. For example: the clinic room was found unlocked posing a risk that residents may have access to medicinal products that may cause harm. Both sluice rooms in the centre were found unlocked which increased the risk of residents accessing chemicals that may cause injury.
- Inappropriate storage was observed in the centre. For example, general medicinal products were observed unsecured in the dining room, posing a potential risk to residents; hoist slings were observed in various areas of the centre including some overlying the hoist with the straps lying on the floor, posing a risk of potential cross-infection or accidental injury; five boxes were observed on the floor in the oratory, impacting the ability to ensure effective cleaning.
- The layout of one of the bays in the two triple rooms in Hill View unit, did not afford sufficient space to allow a chair within the bed space.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' dietary needs were met, as prescribed by a healthcare professional. Food and drinks were properly served.

Staff were attentive, offering encouragement and assistance where required. Staff had completed relevant education in dysphagia management and demonstrated understanding of associated risks, including aspiration pneumonia.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Some residents' care plans lacked detailed information and knowledge about residents to reflect each of their individual needs, to support the provision of person-centred care. For example:

- A review of a sample of care plans found that known triggers and de-escalation techniques (ways to effectively respond to behaviours), were not always fully outlined to adequately guide staff practice to safely interact with residents and to support them during these episodes, and on how to prevent re-occurrence of further responsive episodes.
- A mobility care plan did not accurately reflect the resident's assessed need and required more detail.
- An occupation and recreational care plan needed to be more personalised, stating resident's interests, likes and dislikes.
- While management responded appropriately to safeguarding incidents, a resident who had safeguarding concerns did not have a safeguarding care plan in place.

This is a repeat finding.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The use of restrictive practices was not found to be fully in line with national policy as published on the website of the Department of Health. For example;

- Not all residents who had bed-rails in use as a restraint had an individualised risk assessment in place. In some cases, there was no evidence if other alternatives had been trialled, no documented evidence that the risks of using that restraint had been explained to the resident or their representative prior to use or a signed consent.

Judgment: Substantially compliant

Regulation 8: Protection

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 concern arise. All staff spoken with were clear about their role in protecting residents from all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Based on feedback from residents and a review of the activity schedule, action was required in relation to supporting residents' rights to meaningful occupation and social engagement. For example, there were limited activities planned for the weekends, with an over-reliance on TV planned activities.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Dalkey Community Unit for Older Persons OSV-0000510

Inspection ID: MON-0049398

Date of inspection: 04/03/2026

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
<p>Outline how you are going to come into compliance with Regulation 21: Records:</p> <p>The Person in Charge acknowledges that the arrangements in place for the retention and availability of Resident records required improvement to ensure full compliance with Regulation 21 and Schedule 3 of the Regulations.</p> <p>To address this non-compliance, the following actions are in place:</p> <ul style="list-style-type: none"> • The Registered Provider acknowledges that, notwithstanding interim risk mitigations, Regulation 21 requires that all Schedule 3 records are retained within the designated centre. • A project to return all resident and former resident paper records currently held in secure off site storage to the designated centre has been approved. • Within four months, the following will be completed: <ul style="list-style-type: none"> • All Schedule 3 records transferred securely back to site. • Records stored in locked designated storage areas with authorised access only. • Records organised and indexed to ensure immediate availability for inspection. • The Person in Charge is accountable for: <ul style="list-style-type: none"> • The oversight of transfer and storage. • Verification that all required records are present on site. • Electronic Patient Records (EpicCare) remain the primary operational record system, with paper records retained on site for statutory retention and inspection purposes. <p>The Registered Provider and Person in Charge are satisfied that these measures ensure compliance with Regulation 21 and Schedule 3, and that the introduction of an Electronic Patient Records system mitigates the risk of this non-compliance recurring.</p>	

Regulation 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Registered provider and Person in Charge acknowledge that the governance and management systems in place at the time of inspection required strengthening to ensure the service provided to Residents is safe, appropriate, consistent and effectively monitored. The following actions are implemented or being implemented as part of this action plan to address the deficits identified and to provide assurance of effective governance oversight.</p> <p>Oversight of Physical Environment and Security Governance oversight of the physical environment has been strengthened to ensure residents are protected from identified/foreseeable risks.</p> <ul style="list-style-type: none"> ▪ Controlled access arrangements are being put in place on all clinical rooms and sluice rooms where they do not presently exist. These areas will be secured when not in use and access is restricted to authorised staff only. ▪ Clear signage is displayed to re-enforce access control requirements. ▪ Daily safety checks are completed by the nurse in charge, with findings escalated to the Person in Charge as required. <p>Information Governance and Records Management</p> <ul style="list-style-type: none"> ▪ The Registered Provider has strengthened governance systems to ensure: ▪ Clear accountability for records retention. ▪ Ongoing compliance monitoring. ▪ As a specific governance control: ▪ The return of all Schedule 3 records currently stored in secure off site storage to the designated centre within four months. ▪ Progress is monitored through local governance meetings and processes. ▪ The Person in Charge is responsible for: ▪ Confirming completion of on site transfer. ▪ Providing assurance that all records are securely stored and accessible. <p>Oversight of Residents' Care Needs and Care Planning</p> <ul style="list-style-type: none"> ▪ All registered nurses have being scheduled to complete refresher care planning training to improve the quality, consistency, and person-centered nature of nursing assessments and care plans. ▪ Care plans clearly reflect Residents' assessed needs, including guidance on known triggers and de-escalation strategies where required, to support safe delivery of care. ▪ Care plans are reviewed at least every four months, or more frequently where a resident's needs change in line with Regulation 5(4). ▪ The care plan audit tool is being reviewed to ensure it is sufficiently robust to identify deficits in care planning, including behavioral supports. ▪ Ward Managers are responsible for completing monthly care plan audits, with findings 	

reviewed by the Person in Charge.

- Audit outcomes are used to inform quality improvement actions, which are tracked to completion.
- A newly appointed staff nurse with extensive experience in EpicCare provides support and supervision to staff to maintain and improve proficiency with electronic care planning.

]

Regulation 17: Premises

Substantially Compliant

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

Ventilation, Heating and Medication Storage

- The clinical room temperature and fridge temperatures are now checked and recorded daily, in line with best practice for medication storage.
- Air conditioning controls in the clinical rooms have been regulated to ensure temperatures remain within safe limits to maintain the efficacy of medications.
- Temperature monitoring records are reviewed regularly by the Clinical Nurse Manager or nurse in charge, and any deviations are escalated promptly to ensure timely corrective action.

Secure Storage and Restricted Access

- Access to the clinical rooms and sluice rooms is now controlled, and these rooms are kept locked when not in use.
- Signage is displayed to reinforce the requirement that these areas remain secure at all times.

Storage of Medications, Equipment and Infection Prevention

- All medicinal products are stored securely in designated locked storage areas and are no longer accessible in communal areas such as dining rooms.
- Residents hoist slings are individually labelled and stored in residents' rooms.

Storage of Records and Environmental Cleanliness

- Storage capacity within the designated centre is being reviewed and will be reconfigured to accommodate:
 - Secure retention of all Schedule 3 records.
 - Safe access for authorised staff only.
 - Within four months, all resident records currently held in secure off site storage will:
 - Be relocated to the designated centre.
 - Stored in a designated secure area.
 - This action ensures:

- Compliance with Schedule 6 premises requirements.
- Removal of inappropriate storage practices.

Bedroom Layout and Resident Safety

- As per the Statement of Purpose and Function the bed space identified in the inspection report is designated for Residents with enhanced mobility and low dependency needs only.
- Admissions to these bed spaces are restricted to Residents who meet the criteria to ensure sufficient space, comfort and safety.

]

Regulation 5: Individual assessment and care plan

Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

- A focused review of all care plans is being undertaken to ensure they accurately reflect Residents assessed needs and preferences, with particular emphasis on:
 - Clearly documented known triggers, early warning signs, and individualised de-escalation strategies to guide staff practice and prevent reoccurrence of responsive behaviours.
 - Mobility care plans that accurately reflect current assessments, including required levels of support, equipment and risk management strategies.
 - Individual care plans that reflect each Residents interests, likes, dislikes and preferred activities.
 - The development of a safeguarding care plan where safeguarding concerns have been identified, in addition to appropriate safeguarding responses and notifications.
 - The care plan audit process has been strengthened and revised to ensure it is sufficiently robust to identify all possible gaps/omissions in respect of Resident care profiles, while ensuring a full summary of likes/dislikes, potential triggers and behavioural support planning.
 - Local Clinical Nurse Manager(s) complete monthly care plan audits, with findings reviewed by the Person in Charge.
 - All registered nurses have been scheduled to complete refresher care planning training to improve the quality, consistency, and person-centred nature of nursing assessments and care plans.

]

Regulation 7: Managing behaviour that is challenging	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:</p> <ul style="list-style-type: none"> • Individualised restrictive practice risk assessments are now in place for all Residents for whom bed rails or floor beds are in use. These assessments clearly outline the clinical rationale for use, the specific risks and benefits, and the measures required to reduce/avoid potential harm. • There is documented evidence that alternative measures are trialed and evaluated prior to the use of a restrictive practice. • The risks associated with the use of bed rails and floor beds are explained to residents, and where appropriate to their nominated representatives, in line with residents' capacity and preference. • Informed consent is obtained and clearly documented prior to the introduction of any restrictive practice, with signed consent retained in resident record. • All restrictive practices are clearly documented within residents EPR, including ongoing review dates and monitoring arrangements. • The use of restrictive practices is reviewed regularly to ensure they remain necessary, proportionate, and in line with Residents assessed best interests and welfare. <p>]</p>	
Regulation 9: Residents' rights	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 9: Residents' rights:</p> <p>There are sufficient staff on duty to support appropriate activities for Residents at weekends when designated activities staff are not present. These activities are tailored to each Resident's preferences, interests, and past hobbies, while also considering their age, gender, and varying levels of cognitive function. All meaningful activities are documented in the individual nursing care plans.</p> <p>Staff will be assigned to facilitate activities that engage Residents in group and recreational options such as ball games, karaoke, and bingo. There are also plans to introduce a Magic Table to further enhance resident engagement and participation.</p> <p>]</p>	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/08/2026
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	30/08/2026
Regulation 21(3)	Records kept in accordance with this section and set out in Schedule 3 shall be retained for a period of not less than 7 years after the resident has ceased to reside in the	Substantially Compliant	Yellow	30/08/2026

	designated centre concerned.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/08/2026
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).	Not Compliant	Orange	31/05/2026
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.	Substantially Compliant	Yellow	10/04/2026
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	31/05/2026

