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:	The Fern Dean
Name of provider:	SRCW Limited
Address of centre:	Deansgrange Road, Blackrock, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	12 November 2025
Centre ID:	OSV-0000759
Fieldwork ID:	MON-0047920

About the designated centre

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

The Fern Dean Nursing Home is set in its own gardens close to Blackrock in Co. Dublin. It is a purpose built nursing home, which can accommodate 140 male and female residents over the age of 18 years. The centre comprises of 126 single and seven double en suite bedrooms, set across three floors. Each floor has its own dining and sitting rooms. On the ground floor there is a hair salon, an oratory and a private room that visitors can use. There is 24 hour nursing care, and residents with cognitive impairment and or dementia are welcome. The centre can also accommodate respite and convalescent residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	135

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
Wednesday 12 November 2025	07:10hrs to 15:40hrs	Aoife Byrne	Lead
Wednesday 12 November 2025	07:10hrs to 15:40hrs	Aislinn Kenny	Support

What residents told us and what inspectors observed

Inspectors found that The Fern Dean was a well-run centre where residents were supported to enjoy a good quality of life by a team of staff who were kind and caring. From what inspectors observed and from what residents told them, residents were happy with the care and support they received. The centre had a relaxed and friendly atmosphere. There was a large number of residents who were living with a diagnosis of dementia or cognitive impairment who were unable to express their opinions on the quality of life in the centre, however they appeared to be content and comfortable. Those residents who could express their opinions informed inspectors that they were content about their lived experience in the centre, with comments such as "the food is delicious" ,"it's a fabulous place" and "staff are so kind and prompt at answering call bells". A visitor spoken with told the inspectors "There's really good communication with the management team, I am happy with the support provided".

The Fern Dean is located in Blackrock, Co. Dublin. The centre is registered for 140 residents with five vacancies on the day of the inspection. The centre includes 126 single bedrooms and seven twin bedrooms, all of which contained en-suite facilities. The centre was set out over three residential floors and a basement which contained auxiliary facilities such as the kitchen, laundry and staff changing areas. Each floor was accessible by stairs and a lift. Residents had access to enclosed garden areas from the ground floor, all of these doors were open allowing for easy access.

The inspectors arrived to the centre early in the morning and walked around observing the morning routine for residents. Some residents were still sleeping, others were preparing for their breakfast and getting ready for the day.The inspectors spoke with staff working in the centre. Later in the morning residents were seen eating breakfast in their bedrooms or in the dining room. Other residents were seen mobilising around the centre or sitting and relaxing in the sitting room.

During the walk around of the centre, the inspectors observed that the boiler room on the ground floor contained various electrical items such as televisions, a microwave, hoists, a bottle of methylated spirits and tools. This was a repeat observation from the previous inspection in November 2024. The provider was issued with an immediate action to remove the items before the end of the inspection. In the basement area and underground car park inspectors also observed a variety of items being stored here including past residents' furniture items, a box of continence wear, a broken bed-pan washer and stainless steel unit. Inspectors were informed these were stored temporarily while waiting for refurbishment works to commence. Inappropriate storage was observed throughout the centre and items were seen to be stored in a stairwell.

The centre was decorated to a high standard, tasteful artwork and comfortable furnishings were seen throughout the centre. Residents were able to personalise their own rooms and many contained items from home, belonging to that individual.

For example, inspectors saw residents' brought some furniture from home, others had plenty of plant pots. Residents spoken with reported to be happy with their rooms, including the cleanliness of them and were appreciative of the support they received from household staff. Communal areas were large and inviting, there was comfortable seating throughout and inspectors observed that most chairs and sofas were free from damage.

Many residents were observed walking up and down the unit independently throughout the day. Directional signage was in place around the centre which facilitated residents to find their way around the home. The corridors were wide with hand-rails on either side, facilitating residents to mobilise independently. Staff were observed to be kind and person-centred in their approach to residents and were busy attending to residents throughout the day. Inspectors observed that call-bells were answered promptly throughout the day.

Residents had access to group activities throughout the day. Residents described the activities as great. They said there was a great variety and those spoken with said they enjoyed the music sessions, bingo and drums. The provider had refurbished a lounge area which will be used once a month as a pop up restaurant called "Chapter two", and will be a fine dining experience for residents and their families.

The following two sections of the report present the findings of this inspection concerning governance and management arrangements in place in the centre and how these arrangements impacted 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

This was an unannounced inspection carried out to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulation 2013 (as amended). Overall, the findings of this inspection was that this was a well-governed centre. The inspectors found that the governance and management arrangements in place were effective and ensured that residents received person-centred care and support. However, some areas for improvement were required in the effective and consistent oversight of the premises, fire precautions and care plans.

The Fern Dean is a designated centre, registered to accommodate 140 residents, owned by SRCW Limited who is the registered provider. The company, SRCW Limited has three directors, one of whom was involved in the day to day management of the centre. There is a clearly defined management structure that identifies the lines of authority and accountability. This inspection was facilitated by one of the company directors and the person in charge.

There were good management systems occurring such as clinical governance meetings, staff meetings and residents meetings. It was clear these meetings ensured effective communication across the service. The quality and safety of care was being monitored through a schedule of monthly audits including audits on call bells, care plans and restraints. However, fire safety audits were not occurring and as a result findings by inspectors were not identified by the registered provider prior to this inspection. This is further discussed under Regulation 23: governance and management.

An annual review of the quality and safety of care delivered to residents had been completed for 2024. The report included the opinions and feedback on the running of the centre from the residents. A quality improvement plan for the centre for 2025 was available and had been implemented.

There was a complaints procedure which was on display within the centre. Residents' complaints were listened to, investigated and complainants were informed of the outcome and given the right to appeal. Complaints were recorded in line with the regulations. Advocacy service contact details were displayed throughout the centre for support with complaints.

Staff training records showed that staff had completed supplementary training appropriate to their roles, such as medication management and manual handling, to support them in delivering person-centred and safe care to residents.

Regulation 16: Training and staff development

Staff training records confirmed that all staff were up-to-date with important training modules, such as infection prevention and control and fire safety.

Judgment: Compliant

Regulation 19: Directory of residents

An updated directory of residents was maintained in the centre. This included all of the information as set out in Schedule 3 of the regulation, including the name and contact details for the resident's next of kin and the date of the resident's admission.

Judgment: Compliant

Regulation 22: Insurance

A contract of insurance was available for review. The certificate included cover for public indemnity against injury to residents and other risks including loss and damage of residents' property.

Judgment: Compliant

Regulation 23: Governance and management

Some actions were required to ensure that the management systems were effective to ensure the services provided are safe, appropriate and consistent. For example:

- Further management oversight was required to ensure the premises was a safe and comfortable living environment for all residents and to ensure compliance under regulation 17.
- There was no complete audit of fire safety and fire precautions taking place despite this being on the audit schedule as due to occur on a twice yearly basis.
- Inspectors found that following the use of an emergency restraint used by staff, there had been no follow up by management on this. Improved oversight was required to ensure that the policy was followed and implemented correctly.
- Further oversight was required in relation to fire safety in particular the boiler room. A fire risk assessment was in place with a risk rating of 12, however the controls in place such as weekly visual inspection of the boiler room were not occurring. There was no documented evidence that these inspections were occurring and inspectors observed the inappropriate storage of electrical equipment and combustible materials in this area.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts of care. These were seen to be agreed on admission to the centre and detailed the services provided to each resident, whether under the Nursing Home Support Scheme or privately. The type of accommodation was stated along with fees, including for services which the resident was not entitled to under any other health entitlement.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a clear complaints procedure in place that reflected the requirements of the regulations. This was displayed in the main reception and in each unit. The complaints log identified the issue, outcome and level of satisfaction recorded.

Judgment: Compliant

Quality and safety

The inspectors found that the residents of The Fern Dean were receiving a good standard of care. This care was seen to support and promote residents to enjoy a good quality of life. Social activities were organised throughout the week. The inspectors observed that all staff interactions with residents were held with respect and kindness throughout this inspection. The inspectors found that the overall condition of the premises had improved since the last inspection. A programme of painting works had commenced in January 2025 and as per the compliance plan was due to be complete by 30 September 2025. However, the second floor remained outstanding and required improvements. Inspectors were informed by the provider that this was due to be completed by December 2025. Furthermore, improvement was required in the oversight of fire precautions and assessment and care plan. This is further discussed under the relevant regulations.

Inspectors reviewed a sample of residents' records such as observation charts, assessments and care plans. Care plans were generally individualised to reflect the health and social needs of the residents and completed as per regulatory time frames. Assessments had been carried out and were used to guide care. However, improvement was required to ensure that the information in some residents' care plans was up-to-date and reflected the current needs of the residents as further discussed under Regulation 5: Individual assessment and care plan.

Care plans were in place for 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). On the day, these appeared to be managed in a way that kept residents, visitors and staff safe, while also having a minimal impact on the person exhibiting these behaviours. Referrals to external services such as a geriatrician and psychiatry of later life were in place to provide a person-centred approach to care. The registered provider had ensured a restrictive practice register was in place in this centre. A small number of residents used bed rails and inspectors found there were risk assessments in place for this. However, from a review of documents inspectors found that on one occasion staff had utilised a bed-rail as an emergency restraint and there was no evidence of review of this practice by the management team following this as discussed under Regulation 23: Governance and Management.

Comprehensive systems were seen to be in place for medicine management in the centre. Medicine administration was observed to be in line with best practice guidelines. Controlled drugs were carefully managed in accordance with professional guidance for nurses. Inspectors observed the temperature in the medication room on the second floor was not in line with guidance and required review to ensure the room was kept at optimum storage temperature.

The registered provider had systems in place to safeguard residents from abuse. The provider had a safeguarding policy to guide staff in recognising and responding to allegations of abuse. Staff had received appropriate training and demonstrated an awareness of this training. Safeguarding care plans were in place for residents with an identified safeguarding need. The provider was not a pension agent for any resident.

Although the centre was suitably decorated and laid out to meet the needs of the residents, some parts of the centre were found to require repair or maintenance input in order to ensure that all matters set out in Schedule 6 of the regulations were met. In addition, inspectors found that there was insufficient storage space in the centre to ensure that maintenance items and items for repair were stored appropriately. For example, inspectors observed a box of residents' incontinence wear supplies and clinical instruments were being stored in an outside car park and therefore may be exposed to moisture. In addition there was storage of maintenance and general items in the plant room, water pump room, and under a stairwell. This was a repeat finding and is discussed further under the relevant regulation.

Some fire doors in the centre required a full review to ensure they were sufficient to contain the spread of fire and smoke. The provider had arranged a fire safety risk assessment from a competent person and nurses completed some daily fire checks as part of their daily duties. Further oversight was required to ensure there was a proactive response to fire safety in the centre.

Regulation 17: Premises

Action was required to ensure compliance with Regulation 17 and the matters set out in Schedule 6 to ensure that the premises promoted a safe and comfortable environment for all residents. For example:

- Some areas were not kept in a good state of repair, for example; the flooring in some areas was raised at the saddleboard and created a falls risk to residents.Inspectors were told that the provider was aware of this and was working to replace the saddle boards.
- There was inappropriate storage throughout the centre and the lack of space to store maintenance items meant that they were being stored in various areas in the centre such as the car park, water tank room, and under a stairwell. This was a repeat finding from the previous inspection and the

provider had committed to addressing this in their compliance plan by implementing a weekly check of the underground care park and plant room. ?

- Wear and tear to architraves, door and handrails on the second floor were outstanding. This is a repeat finding and was due to be complete as per the compliance plan by 30 September 2025.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors followed up on the compliance plan from the previous inspection and found that there were repeat findings and areas that required further oversight. For example;

- An immediate action was issued to the provider to remove flammable items from the plant room to reduce the risk of fire in this area.

While the registered provider had taken some action to address the containment of smoke and fire from the previous inspection by repairing the seals on some doors, further review in this area was required. For example:

- Some fire doors had large gaps and were not fully sealing when closed, which did not provide assurance that they would provide effective containment in the event of a fire. In particular the fire door at the exit of the laundry, an area of high risk, was not fully closing.This is a repeat findings from the previous inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The inspectors observed good practices in how the medicine was administered to the residents however, storage of medicines required review. For example;

- Some medicinal products supplied for residents were not stored safely or in line with the product advice. Inspectors reviewed the temperature records for the medication rooms and found that despite checks being in place, one medication room showed room temperatures of 28 degrees Celsius for 13 nights and on one occasion a temperature of 31.1 degrees Celsius. Labelling of the medications stated that storage was required at a temperature maximum of up to 25 degrees Celsius. This could pose risks with respect to the effectiveness of those medications.

This was a repeat finding from the previous inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Residents had care plans in place that were initiated within 48 hours from admission and reviewed at regular intervals, from a review of a sample of residents' records, inspectors found that some further action was required in relation to ensuring care plans were based on assessed needs and contained up-to-date information. This was evidenced by the following:

- A resident who had a recent change in their dietary needs did not have this change fully updated in their care plan.
- While an assessment was in place for a resident who was deemed a high risk of absconding there was no corresponding care plan in place. Further review indicated that the residents' dependency needs had also changed prior to the assessment.
- One residents care plan referred to their mobility being restricted however, this restriction was no longer in place and the resident's care plan had not been updated to reflect this.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

A positive and supportive approach was taken by staff in their care of a small number of residents who intermittently experienced episodes of responsive behaviours (how people with dementia or other conditions may communicate express their physical discomfort, or discomfort with their social or physical environment). Staff were attentive to residents' cues and needs for support.

Judgment: Compliant

Regulation 8: Protection

The registered provider had taken all reasonable measures to safeguard residents from abuse. Training in the safeguarding of vulnerable adults was provided to staff and staff demonstrated an awareness of the need to report, if they ever saw or heard anything that affected the safety or protection of a resident. Residents

reported feeling safe in the centre. Any allegations or incidents regarding safeguarding of vulnerable adults, were investigated and reported to the appropriate organisations as required.
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 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Fern Dean OSV-0000759

Inspection ID: MON-0047920

Date of inspection: 12/11/2025

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 23: Governance and management	Substantially Compliant

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

Maintenance team completes 6-point fire door inspections twice annually. These were carried out in March 2025 and September 2025. A professional fire adviser from Phoenix STS conducts a full Fire Risk Assessment/Audit annually. The latest audit was completed in September 2025, though the report was not available on the day of inspection. The Clinical Team performs weekly visual inspections and reports any visible damage promptly.

PIC updated the audit schedule to reflect current practice and ensure alignment with regulatory requirements. Compliance is monitored by the Director of Nursing through quarterly governance meetings, ensuring sustained oversight and assurance. Facilities team is working with external providers to improve turn around times between issues being identified/report and repairs being completed.

Oversight arrangements for the use of restraints have been strengthened to ensure the Restrictive Practices Policy is consistently followed and effectively implemented. All episodes of emergency restraint will be reviewed by the Assistant Director of Nursing, focusing on: Quality of documentation; Proportionality of the intervention, Evidence that less restrictive alternatives were considered.

Each incident will be reviewed at the Clinical Governance Meeting to support oversight, learning, and accountability, and at the Quarterly Restraints Committee to monitor compliance, identify trends, and promote the ongoing reduction of restrictive practices.

Boiler room checks have been programmed into the maintenance management software, requiring photo evidence for Maintenance to close out each task.

December: Daily checks by Maintenance with weekly oversight by the Facilities Manager

From January 2026: Weekly checks by Maintenance and fortnightly oversight by the Facilities Manager

From February 2026: Fortnightly checks by Maintenance with monthly oversight by the Facilities Manager

Regulation 17: Premises	Not Compliant

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

All storage issues identified during the inspection were addressed immediately, and inspectors were provided with visual confirmation on the day. In addition, a decluttering project has been scheduled for all maintenance storage areas throughout December to educate the team and ensure ongoing compliance.

Starting January 1, 2026, weekly checks will be programmed into the maintenance management software. These checks will be carried out weekly by Maintenance and fortnightly by the Facilities Manager.

From February 2026, checks will transition to fortnightly by Maintenance with monthly oversight by the Facilities Manager.

A program of work has been scheduled to ensure:

All identified raised saddle boards are replaced by the end of March 2026.

All identified wear and tear to architraves, doors, and handrails on the second floor are painted by the end of March 2026.

These works were already underway prior to the inspection and continued on the day of the visit. Completion will be overseen by the Facilities Manager, and the area will be reviewed as part of environmental walkabouts to ensure the premises is maintained in a good state of repair.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

A program of remedial works has been prioritized to ensure compliance and resident safety. All affected fire doors will be adjusted, repaired, or replaced as necessary to

guarantee they fully close and provide effective fire containment. These works are scheduled for completion by the end of March 2026.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

Corrective measures have been implemented, including increased ventilation and enhanced environmental controls.

It was identified that thermometers were incorrectly positioned near the back of the fridges, causing higher temperature readings due to the heat from the fan.

Clear escalation thresholds have been reinforced, ensuring that any temperature excursion above 25°C triggers immediate management review and corrective action.

Ongoing oversight is maintained by the Person in Charge and Clinical Nurse Manager through regular audits of medication storage and temperature records, ensuring medicines are stored safely and in line with product requirements.

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, all care plans identified during the inspection have been reviewed and updated to reflect any changes in dietary requirements, mobility status, dependency levels, and identified risks. Where an absconding risk was assessed, a corresponding care plan has been developed. Ongoing oversight is maintained through monthly care plan audits conducted by Clinical Nurse Managers and further reviewed at Clinical Governance Meetings.

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.	Not Compliant	Orange	31/12/2025
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.	Substantially Compliant	Yellow	31/12/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	31/03/2026

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/03/2026
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	30/12/2025
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	31/12/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared	Substantially Compliant	Yellow	31/12/2025

	under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			