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:	Ashley Lodge Nursing Home
Name of provider:	Ashley Lodge Nursing Home Limited
Address of centre:	Tully East, Kildare, Kildare
Type of inspection:	Unannounced
Date of inspection:	16 July 2025
Centre ID:	OSV-0000009
Fieldwork ID:	MON-0047615

About the designated centre

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

Ashley Lodge is a single-storey purpose-built centre situated on the outskirts of Kildare town. The centre can accommodate 55 residents, both male and female, for long-term and short-term stays. Care can be provided for adults over the age of 18 years but primarily for adults over the age of 65 years. 24-hour nursing care is provided. Residents' accommodation is arranged over three wings which meet at the reception and communal rooms. Residents' bedroom accommodation comprises 43 single rooms and 6 twin rooms. The majority have en suite facilities. There are three spacious lounges, our Day Room, Library / Visitors Room and Sun Room, for residents to relax and enjoy the many in house social activities. Our Kitchen serves a large bright dining room, where meals are served.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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 16 July 2025	08:35hrs to 17:00hrs	Karen McMahon	Lead
Wednesday 16 July 2025	08:35hrs to 17:00hrs	Rachel Seoighthe	Support

What residents told us and what inspectors observed

The inspectors spoke with a number of residents and relatives and spent time observing residents' routines and care practices in the centre in order to gain insight into the experience of those living there. Residents appeared relaxed and those spoken with were content with the care they received living in the centre. However, the inspectors found that residents' rights and some of the governance and management systems in place needed to be improved to ensure the service was safe and appropriately monitored.

The centre is a purpose-built designated centre, based in the countryside of County Kildare.The centre is spread out over one floor and has 55 registered beds. The centre is split into three wings that branch off from the main reception area.

Overall the centre was seen to be clean and maintenance works were observed to be in progress to address the findings of previous inspections. These works included replacement of flooring, painting and decorating, and the replacement of bedroom furniture. There were suitable ancillary services throughout the building, including appropriate hand washing facilities.

Bedrooms consisted of a mix of single and multi-occupancy bedrooms. Many residents had personalised their rooms with belongings and photographs from home. Residents had access to either en-suite facilities or a shared bathroom.

There was a choice of communal spaces available to residents. These included a dining room, two sitting rooms and a library. Communal spaces were seen to be utilised throughout the day of inspection.

A hair salon had recently been added to the centre and was used when the hairdresser was present.

There was a small enclosed patio area available to residents. The smoking area was located here and inspectors observed there was not much greenery or plants to make the space visually attractive for those using it. Residents could only access other outside garden areas under the supervision of staff and through exiting the front door, which was restricted for the safety of all residents.Two residents who spoke with the inspectors said they loved walking but said if they wanted to walk around outside they had to walk around in circles in the small patio area. Another resident said they would love to see a bit of the greenery when they were sitting out there instead of looking at the fencing. Inspectors observed that much of the outside spaces were not being used to enhance the lived experience of the residents, and outside walks of the grounds were included as an activity in the weekly activity schedule.

Meals in the centre were served in the dining room or residents' bedrooms if this was their preference. The lunchtime experience was carried out over two sittings as

it was not large enough to facilitate all residents who chose to eat there. There was a choice provided at mealtimes. The inspectors observed that dinnertime in the dining room was a relaxed and social occasion for residents. The meals were home-cooked on-site in the large kitchen. Residents were provided with assistance where required and the staff were observed not to rush residents.

Activities were seen to take place during the morning and afternoon of inspection. Activities took place in the two sitting rooms. However, there was limited recreational and occupational opportunities for meaningful activities observed to be provided to residents with impaired cognition. The inspectors observed some residents participating in a ball game activity in the smaller sitting room, however the residents did not appear to to be enjoying or interested in the activity. Some residents chose not to participate and another resident complained that they did not enjoy this activity. Residents told inspectors that the activities on offer were 'ok' but most of the day was spent watching the TV.

A bus outing took place in the locality on the afternoon of the inspection and inspectors were told that outings took place every Wednesday. Residents gave mixed feedback on these outings to inspectors with some saying they enjoyed getting out and about, while others said they do not go anymore as the outings were repetitive and they ended up in the same place every two to three weeks. Alternative suggestions for outings had been given at residents' meetings and management in the centre confirmed they were reviewing the suggestions but had not commenced at the time of the inspection. Some of the alternative suggestions from residents dated back to March this year.

The inspectors spoke with a number of residents, over the day of inspection, all of whom were positive and complimentary about the staff. Those residents who could not communicate their needs appeared comfortable and content. Residents who spoke with inspectors said they never had to wait long for help when they needed it, and that staff always treated them with compassion and respect.

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

Capacity and capability

Overall, the provider and staff working in the centre aimed to provide a good service and support residents living in the designated centre to receive a good standard of care. Residents' healthcare needs were well met. However, this inspection found that improvements were required to the governance and managements systems in place to ensure that a safe service was consistently provided for residents living in the designated centre.

This was an unannounced risk inspection which occurred following the airing of an RTE Investigates programme. Although this centre did not feature in that programme, the centre is one of the 25 nursing homes which are part of the Emeis Group of nursing homes. The purpose of the inspection was to ensure that residents were safe and receiving an appropriate standard of quality care, and to assess the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended).

The registered provider of Ashley Lodge Nursing Home is Ashley Lodge Nursing Home Limited. There were clear lines of accountability and responsibility in relation to the governance and management arrangements for the centre. The person in charge was supported by a regional operations manager and an assistant director of nursing. The other members of the staff team included clinical nurse managers, staff nurses, health care assistants, activity coordinators, domestic, catering and maintenance staff.

On the day of the inspection, inspectors found that there was sufficient staffing levels and skill-mix in place. A member of the clinical management team worked in the designated centre every day, including weekends to ensure appropriate oversight.

There was an ongoing mandatory training programme available to staff. The training matrix provided to the inspectors recorded overall high levels of attendance at training such as infection prevention and control and safeguarding vulnerable adults. There was a training schedule in place for the year to ensure all staff training was kept up-to-date.

There was an accessible complaints policy and procedure in place to facilitate residents and or their family members to make a complaint should they wish to do so. The policy clearly described the steps to be taken in order to register a formal complaint. This policy also identified details of the complaints officer, timescales for a complaint to be investigated and details on the appeal process should the complainant be unhappy with the investigation conclusion.

The complaints log was made available to the inspectors for review. There was one current open complaint. The inspectors reviewed this complaint as well as a number of closed complaints. Inspectors found one of these complaints concerned an alleged safeguarding incident of neglect. The allegation had been appropriately investigated and dealt with, under the complaints procedure, and dealt with according to their local policy on safeguarding. However, inspectors identified that not all areas for learning and quality improvements had been identified throughout the complaints investigation. Furthermore, while there was an audit schedule in place and regular auditing was seen to occur, inspectors found that some audits were not always leading to quality improvements to ensure the service provided is safe, appropriate, consistent and effectively monitored. This is further discussed under Regulation 23: Governance and Management.

Regulation 15: Staffing

There were sufficient staff on duty to meet the needs of the residents and taking into account the size and layout of the designated centre. There was at least three registered nurses on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to regular training and refresher training to ensure their mandatory training was up-to-date. All staff were up-to-date with their fire safety, moving and handling and safeguarding training.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place did not ensure that the service provided to residents was safe, appropriate and consistent. This was evidenced by:

- Auditing was not always leading to quality improvements. A number of monthly audits reviewed on the day of inspection were found to have a repeated action plan recorded. There was no evaluation of the effectiveness of this action plan in practise, and inspectors found, based on these audits, that the actions were not reducing the incidents such as falls or responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).
- Inadequate oversight of records management, as detailed under Regulation 21: Records.
- Systems of monitoring, evaluating and improving the quality of the service were not effectively implemented. For example, feedback from resident meetings in relation to the activities programme was not used to inform quality improvement.

Furthermore, inspectors were not assured that clinical oversight systems in the centre were identifying key opportunities for learning and quality improvement. For example, management in the centre had not identified the following findings of the inspectors, on the day of inspection;

- On two occasions, while a resident was an in-patient in hospital, daily care records had been logged by staff in the centre.
- Results of clinical investigations had not always been followed up by nursing staff in the centre and therefore were not available for review in the resident's medical files.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a policy in place that was reflective of regulatory requirements. There was information about the complaints process displayed on the walls in the centre.

Judgment: Compliant

Regulation 21: Records

The registered provider did not maintain all records as required under Schedule 3 of the regulations. For example:

- Daily progress records did not provide staff with a comprehensive overview of how a resident spent their day. A sample of three records viewed by inspectors indicated that daily entries were copied and duplicated.
- Care planning documentation reviewed had incomplete detail in relation to nutritional care.
- Records in place on food and fluid intake were not populated with sufficient detail. For example, a sample of records of residents who were losing weight dad not provide an accurate description of the quantity of food consumed, therefore the residents' exact nutritional intake was not recorded.

Judgment: Substantially compliant

Quality and safety

The inspectors found that in general, the residents were receiving a good standard of care that supported and encouraged them to enjoy a good quality of life. Dedicated staff working in the centre were committed to providing quality care to residents to meet their needs. The inspectors observed that the staff treated residents with respect and kindness throughout the inspection. However, further

assurances were required in relation to standards of residents' care plan documentation, and opportunities for them to participate in meaningful social and recreational activities to meet their interests and capabilities.

Residents were provided with satisfactory standards of nursing care and had access to timely health care from their general practitioner (GP) and to allied health professionals and psychiatric services who attended the residents in the centre as necessary.

The centre had an electronic resident care record system. Pre-admission assessments were undertaken to ensure that appropriate care and services could be provided to the person being admitted. Residents' needs were assessed on admission to the centre, through validated assessment tools, in conjunction with information gathered from the residents and, where appropriate, their relatives. This informed the development of care plans that provided guidance to staff with regard to residents' specific care needs and how to meet those needs.

Food was freshly prepared and cooked on site with adequate quantities of food and drink provided at meal times. There were adequate numbers of staff available to supervise and support residents at meal times. Residents had access to fresh drinking water throughout the day. However, inspectors observed that not all residents were offered choice regarding the type of snacks and refreshments provided. Furthermore, although snacks were offered to residents by staff at specific times throughout the day, there was no arrangement in place for residents to access snacks and refreshments independently.

There were systems in place to safeguard residents and protect residents from the risk of abuse, including an up-to-date safeguarding policy and procedure. Staff were trained to recognise and respond to allegations of abuse. However, inspectors found that the provider's own safeguarding policies and procedures were not consistently implemented. This is detailed under Regulation 8: Protection.

Residents had access to local and national newspapers and radios. Although, staff made some efforts to provide residents with opportunities to participate in meaningful activities to fulfil their interests and capabilities, there were limited meaningful social activities available on the day of the inspection for many of the residents, including residents with dementia. This was also reflected in feedback from a number of residents who mostly occupied themselves with looking at the television. These findings are set out under Regulation 9: Residents' rights.

Regulation 18: Food and nutrition

Inspectors observed that not all residents were offered choice around snacks and refreshments. For example;

- During a snack and refreshment round, taking place in one of the sitting rooms, only one resident out of five was observed to be offered choice

around refreshments and snacks. The remaining four residents were given tea in beakers without being asked; one resident was seen to call the staff back asking why they were given this as they didn't want it.
- Another resident was assisted to eat a yogurt by staff but no choice was offered around flavours. The resident had to ask, while being assisted to eat the yogurt, what flavour it was.

One resident identified at risk of malnutrition with a MUST (Malnutrition Universal Screening Tool) score of 3 did not have the recommendations of their dietitian followed by staff or reflected in their care planning documentation. Staff who spoke with inspectors on the day of inspection were not aware that a dietetic assessment had taken place. As a result of this, inspectors were not assured that the residents dietary needs were consistently being met, as prescribed by dietetic staff.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Notwithstanding the one occasion observed where care planning was not accurate, as outlined in Regulation 18: Food and nutrition, the majority of care plans were person-centred and reviewed at regular intervals. A review of a sample of resident records demonstrated that care plans were developed following a comprehensive assessment of need. The majority of care plans were reviewed at four month intervals and more frequently if required, informed by updated risk assessments. Care plans detailed the interventions in place to manage identified risks such as impaired skin integrity, risk of malnutrition, and falls.

Judgment: Compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP), and GPs were visiting the centre as required.

Residents had access to a range of allied health care professionals such as physiotherapist, occupational therapist, dietitian, speech and language therapy and tissue viability nurse.

Judgment: Compliant

Regulation 8: Protection

The registered provider did not ensure that all appropriate and effective safeguarding measures were in place. For example, the centre's own safeguarding policies and procedures were not consistently implemented in relation to the completion of preliminary screening assessments for three residents who had sustained unexplained injuries, to rule out any potential safeguarding concerns.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There was an overall lack of meaningful social activities available for residents in the centre, which meant that, for the most part, residents were not participating in activities that interested them and in line with their capacities. This was evidenced by the following findings;

- Inspectors observed a ball game activity taking place in one sitting room where residents had significant physical and cognitive decline. One resident was getting annoyed with the activity while two others appeared uninterested in the activity on offer, another resident was sleeping in the chair. Staff persisted with the activity and did not assess the input of residents or discuss activities of interest with them.
- Four residents who spoke with inspectors said that the activities were limited and that much of the day was spent watching TV. While inspectors observed activities taking place they also observed long periods where residents were sitting in front of the TV.
- Residents further stated that the once weekly bus outings had become uninteresting and repetitive and they were still waiting to go on alternative outings suggested at residents' meetings, some of which dated back to March this year.

Residents did not have appropriate access to outdoor spaces for recreation. One resident stated that they had to walk around in circles in the small enclosed patio area to fulfill their love of walking outside. Another resident who loved sitting outside had to sit in this area that also contained the smoking area, and lacked garden views. While the centre had ample outside areas, this was the only safe enclosed area freely accessible to residents. Access to other outdoor areas was available only when accompanied by staff, subject to staff being available to take them.

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 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ashley Lodge Nursing Home OSV-0000009

Inspection ID: MON-0047615

Date of inspection: 16/07/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of the audits was conducted to ensure that findings lead to quality improvements. Whilst monthly audits are performed, from 1st September 2025, specific action plans will be developed based on the findings of these audits to drive quality assurance and reduce incidents. The effectiveness of these action plans will be evaluated monthly by the Regional Director (RD) during clinical governance meetings with the DON. From 1st September 2025, a daily monitoring system will be introduced to provide stronger oversight of clinical records. Documentation completed by the clinical team will be reviewed daily by the Assistant Director of Nursing (ADON) or Clinical Nurse Manager (CNM), and any identified anomalies will be addressed promptly. By the 31st of August 2025, staff nurses will receive education on the importance of accurate, time-sensitive documentation, which will be used to drive quality improvement and reflect the delivery of high quality, individualised resident care. This process will be reviewed monthly at clinical governance meetings by the Regional Director (RD).	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: From 1st September 2025, a daily monitoring system will be introduced to provide oversight of clinical records, such as progress notes. Documentation completed by the clinical team will be reviewed daily by the Assistant Director of Nursing (ADON) or Clinical	

Nurse Manager (CNM), and any anomalies, including duplicated entries, will be addressed promptly.
By the 31st of August 2025 Staff nurses will receive education on the importance of accurate, time-sensitive documentation to support quality improvement. Regular audits of progress notes will be conducted to monitor practices and identify areas for improvement. This process will be reviewed monthly at clinical governance meetings by the Regional Director (RD) with the DON.

By the 8th of September, a comprehensive review of nutrition care plans will be conducted to ensure they are person-centred.

By the 30th of September 2025, education will be provided to staff to support the development and updating of care plans in line with residents' evolving care needs.

By the 30th of September, a multidisciplinary team (MDT) referrals tracker will be implemented to ensure timely integration of recommendations into care plans. Regular monitoring of compliance with residents' records and documentation will be conducted by the Assistant Director of Nursing (ADON) or Clinical Nurse Manager (CNM) and reviewed monthly by the Regional Director (RD) at clinical governance meetings with the DON.

A review was conducted on the system for documenting food and fluid intake. A revised system is now in place that clearly records food and fluid intake for residents who are assessed as at risk of malnutrition- complete

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
By 30th of September 2025 all staff will be educated re the importance of resident autonomy and choice, effective communication strategies, recognising and considering nutritional requirements, cultural preferences, and specific needs of each resident.

A risk assessment was conducted regarding the requirement for access to snacks and beverages. To mitigate the identified risk, residents were informed on 25th August 2025 about the available snacks and beverages, as well as their location and how to access these snacks- complete

By the 8th of September, a comprehensive review of nutrition care plans will be conducted to ensure they are person-centred.

By the 30th of September 2025 education will be provided to staff to support the development and updating of care plans as residents' care needs evolve.

By the 30th of September, a multidisciplinary team (MDT) referrals tracker will be implemented to ensure timely integration of recommendations into care plans. Regular monitoring of compliance with residents' records and documentation will be conducted by the Assistant Director of Nursing (ADON) or Clinical Nurse Manager (CNM) and reviewed monthly by the Regional Director (RD) during clinical governance meetings with the DON.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The centre's policy on Safeguarding and Protection of Residents, including Recognising and Responding to Allegations of Abuse, will be consistently implemented to identify unexplained injuries or bruising. Such incidents will be thoroughly investigated and appropriate actions taken post investigations. By 30th of September clinical staff will complete additional training to ensure both appropriate and safe handling of residents and also the need to consider the potential root causes of unexplained bruising/other injuries, including the risk of abuse, when investigating.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
By the 31st of August 2025, a comprehensive review of the activity requirements for each resident will be conducted by the Activity Therapist.
By the 30th of September 2025, personalized care plans will be developed to reflect the individual activity needs of each resident arising from the review. The completed review will be incorporated into the home's daily activity schedule.
At monthly resident meetings on 28th August 2025, preferred outing locations were discussed as an agenda item, and outcomes will be implemented accordingly.
By the 30th of September 2025, a review of the external facilities will be conducted to ensure that the residents are provided with opportunities to access suitable external areas for occupation and recreation.

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 18(1)(b)	The person in charge shall ensure that each resident is offered choice at mealtimes.	Substantially Compliant	Yellow	30/09/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	30/09/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in	Substantially Compliant	Yellow	30/09/2025

	Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
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	30/09/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/09/2025
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	30/09/2025