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:	Cahercalla Community Hospital & Hospice
Name of provider:	Cahercalla Community Hospital Company Limited By Guarantee
Address of centre:	Cahercalla Road, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	16 March 2021
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0032089

About the designated centre

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

Cahercalla Community Hospital and Hospice is located on the outskirts of the town of Ennis. It provides care to long-term, respite, and convalescence residents and also has five designated hospice beds. The centre was originally opened as a hospital in 1951, and while there had been significant extensions and renovations since then, the overall the design and layout of the premises was largely reflective of a hospital from this period. The original building consists of a three storey units, Ground floor, St. Joseph's and Sacred Heart. An unused clinical unit beside the ground floor unit has recently been refurbished. This new unit consists of three twin rooms, two single rooms, a large day room and a large dining room. The centre also has a two storey building with two units, Garden wing ground floor and Garden wing first floor. The centre is registered to accommodate 112 residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	81

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 16 March 2021	09:30hrs to 17:00hrs	Catherine Sweeney	Lead
Tuesday 16 March 2021	09:30hrs to 17:00hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

Inspectors spoke with a number of residents on the day on the inspection. Residents said that they felt safe and well looked after in the centre. They said that the staff were kind to them and treated them with respect.

Residents told the inspectors that the national restrictions in place due to COVID-19 had been difficult but that they were very happy to have been vaccinated and felt that things were changing for the better. They were looking forward to receiving visitors in the weeks ahead. Residents spoken to told inspectors that they were looking forward to being able to attend the church during holy week.

Inspectors observed a resident being facilitated to have an on-site visiting arrangement in place. A family member told the inspector that this had been facilitated by the new management team and had made 'a huge difference to the quality of life of the resident'. The visiting arrangements were observed to have been risk assessed and facilitated within the Health Protection Surveillance Centre (HPSC) visiting guidelines.

Inspectors observed improvements in the opportunities available to residents in relation to social engagement. An activity schedule for all residents was being developed with the residents to ensure that social activities were appropriate and in line with residents wishes. The schedule included group and individual activities including, exercises to music, baking, bingo, arts and crafts, and pampering and relaxations sessions. Residents told the inspectors that they were glad to be involved in this process.

A residents forum had also been established. Residents told the inspector that they had attended a meeting where they had been updated in relation to the visiting guidelines. They had received an update on social distancing, hand washing and the use of personal protective equipment (PPE).

A number of residents were observed to be enjoying a daily newspaper. One resident explained to the inspector that they was very pleased and described getting their newspaper as 'the highlight of their day'. This issue had been addressed since the last inspection.

Residents told inspectors that they enjoyed the food in particular the brown bread and cakes made on site by kitchen staff. Inspectors observed staff in the kitchen making shamrock biscuits in preparation for the celebration of St.Patrick's Day.

Capacity and capability

The provider of this centre is Cahercalla Community Hospital Company Limited by guarantee. The provider had a poor history of compliance with regulations. Repeated non-compliance in areas such as governance and management, individual assessment and care planning, health care and staffing resulted in the Chief Inspector having significant engagement with the provider since May 2019.

The registered provider failure to address the non-compliance's had resulted in poor outcomes for residents. An inspection carried out over three days in January and February 2021 found that action had not been take to address the non-compliance's. The Chief Inspector issued a notice of proposal to cancel the registration of the centre.

The provider made a representation within 28 of the notice being issued. The representation outlined a revised organisations structure. The provider had enlisted the services of Mowlam Healthcare services to participate in the management of the centre. This service company was represented in the centre by a care director, a regional manager and a person in charge.

This was a risk inspection completed by inspectors of social services to review

- the detail of the submitted representation,
- the non-compliance's of the last inspection
- unsolicited information received by the Chief Inspector since the last inspection

The new management team were on site on the day of inspection. The newly appointed person in charge facilitated the inspection. The person in charge was supported on-site by an assistant director of nursing and a service manager. The management team had commenced their roles in the centre three weeks prior to this inspection. All requested documents were made available for review in a timely and organised manner.

The management team had reconfigured the accommodation in the centre reducing the units from five to four. This allowed for the reallocation of staff throughout the centre.

A review of the staffing resources was in progress. A recruitment process was in place for clinical nurse managers to ensure adequate nursing support and supervision. A review of the availability of social care staff was required to ensure that all residents had the opportunity for social engagement appropriate to their assessed needs.

There was significant gaps in staff knowledge and in the training records in the centre. This was acknowledged by the incoming management team and evidenced in the management meeting records on file. A plan is in place to address the deficits in training and to introduce a system of recording training so that training gaps can be identified and managed.

Inspectors found that the interim arrangements for the training and supervision of

newly recruited management and care staff required review. A formal induction programme was required to ensure that all newly recruited staff received appropriate training in the new management systems that were in the process of being introduced to the centre.

A review of the complaints log found that improvement had been made in the management of complaints. The complaints policy had been revised in line with regulation 34. However, information received by the Chief Inspector detailed a complaint that was under investigation by the provider. This complaint was not logged in the complaints register.

Unsolicited information received by the Chief Inspector in relation to staffing, complaints and health care was largely substantiated, however, an appropriate plan had been developed by the incoming management team to address the issues raised.

Regulation 14: Persons in charge

The newly recruited person in charge was a suitably qualified and experienced person. They has a strong presence in the centre.

Judgment: Compliant

Regulation 15: Staffing

The management team in the centre had been restructured and there was now a person in charge in position who was supported by an assistant director of nursing and a general service manager. The provider was in the process of recruiting five clinical nurse managers.

A review of the staffing available to support the social and psychological well being of the residents was required. The activity schedule was developed so that the activity coordinator could spend time in each unit. There was one full time activities coordinator available on the day of the inspection. This meant that the time the activity coordinator spent on each unit was limited and was not adequate to meet the assessed social needs of the residents.

There was one nurse and one carer rostered on each unit for night duty. One of the nurses on night duty was allocated to be the nurse in charge of the centre each night. However, the nurse in charge was not able to leave their unit to support other units, as they would be the only nurse on duty. A review of staffing numbers for night duty was required to ensure that staffing levels were adequate for the delivery of care and the supervision of staff and for the size and layout of the building.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found that while arrangements were in place to recruit five clinical nurse managers, the interim arrangements for supervision of staff was not clear.

Newly recruited management nursing and support staff required a formal induction which included supervision and mentoring.

Judgment: Not compliant

Regulation 21: Records

A new system of documentation was being introduced. This will include a new a new nursing documentation system, a centre-specific auditing system, and a review and up-date of all schedule 5 policies.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management team were in the process of introducing a suite of management systems to ensure that going forward, the service provided in the centre would be safe, appropriate, consistent and effectively monitored. These management systems included

- monthly governance meetings with the provider and the management team, quality and safety meetings, and staff meetings.
- text communication system for all staff
- a centre-specific auditing system
- a revised electronic nursing documentation system
- revised risk management system
- revised system of policy management

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A system of documenting complaints is in place. The complaints policy had been updated and contained all the requirements under regulation 34. A review of the complaints register found that all documented complaints received by the incoming management team had been addressed in line with the centres policy. However, information received by the Chief Inspector detailed a complaint that was under investigation by the provider. This complaint was not logged in the complaints register.

Judgment: Substantially compliant

Quality and safety

This inspection followed-up on the quality and safety issues identified on the last inspection in January 2021. Overall, inspectors found that some improvement had been made to the quality and safety of care in the centre. The management team had identified the deficits in care delivery and a plan had been developed to address the non-compliance's.

Some improvement was noted in the documentation of nursing records. All resident records had been uploaded onto the existing electronic system since the last inspection. However, the quality of the documented assessments and care plans remained poor. The management team had identified the deficits in the quality of nursing documentation and there was a plan was in place to address these issues through training and supervision.

At the time of the inspection the centre was recovering from and outbreak of COVID-19. A contingency plan was in place for any further outbreak. An isolation area was identified and familiar to staff. Hand hygiene was good on the day of inspection. A number of staff were observed carrying and using pocket hand sanitisers. Improvements were required in implementation of colour system for cleaning and disinfection, and in ensuring effective cleaning of showers in the kitchen area.

The management team had reviewed and revised the visiting policy in the centre. Visiting was now facilitated in line with the HPSC guidelines.

Residents had access to a doctor of their choice and were supported by a team of allied health care professionals.

The quality of life for residents in the centre was observed to have improved. Residents told the inspectors that communication from the new management team had improved and that they felt they were being listened to.

Regulation 11: Visits

A review of the visiting arrangements had been conducted by the new management team. Visiting arrangements were now in line with the HPSC guidelines for visiting in a residential centre. Both window and compassionate on-site visiting was observed to be facilitated on the day of inspection. Resident feedback in relation to visiting arrangements was positive.

Judgment: Compliant

Regulation 27: Infection control

Improvements were required in infection prevention and control in the following areas:

- The colour coding system for cleaning and disinfection was not implemented and as a result there was a risk of transmission of infection
- A number of areas required more effective cleaning including the cleaners room, the store room and the showers in the kitchen area.
- The procedure employed by cleaners to empty buckets required review, as the sinks were too high. The person in charge gave a verbal agreement to address this in the days after the inspection.
- There were some gaps in the cleaning schedules reviewed
- Social distancing measures were not always observed by staff when they were on their break, or at times when residents were in communal spaces such as dining and sitting rooms.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Some documented assessments did not appropriately reflect the needs of the residents. For example, a resident with unexplained significant weight loss was assessed as being low risk of malnutrition. The accurate care needs of a residents were therefore not correctly documented in the residents care plans.

Judgment: Not compliant

Regulation 6: Health care

All residents had been reviewed by their general practitioner (GP) since the last inspection. Residents had unrestricted access to a GP of their choice. Residents also had access to a team of allied health care professionals including physiotherapy, dietitian, speech and language therapy and psychiatry of later life.

Judgment: Compliant

Regulation 9: Residents' rights

Some progress was noted in relation to residents rights. An activities schedule was in development and was displayed in a prominent place for ease of resident access. An activity coordinator was observed facilitating small group activities. The activity coordinator worked across the four units in the centre. On-going development and improvement was required to ensure that all residents had timely access to opportunities for the social engagement of their choice.

Resident's meetings had recommenced. The agenda of these meetings included the communication of changes in the centre such as visiting restrictions due to COVID-19. The meetings also facilitated the residents to participate in any the changes in the centre, such as the development of the activity schedule and to discuss any issues of concern they may have.

Residents had access to a daily national newspaper, television and radio.

Staff were observed to communicate respectfully to residents and residents appeared comfortable in the company of staff.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cahercalla Community Hospital & Hospice OSV-0000444

Inspection ID: MON-0032089

Date of inspection: 16/03/2021

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A comprehensive review of rosters has taken place to ensure that staffing levels and skill mix are always sufficient to meet residents' assessed care needs. The PIC will monitor the rosters closely to ensure that planned rosters are implemented in practice. The Person in Charge (PIC), supported by an Assistant Director of Nursing (ADON) and Clinical Nurse Managers (CNMs), will produce and monitor the staff roster, always ensuring that a suitable skill-mix of staff are deployed, whose duties are allocated appropriately; that there is always a suitable ratio of clinical staff to residents to enable all care needs to be safely and effectively met; and that effective supervision, support and cohesive teamworking are integral to the culture of the hospital. The ADON and CNMs will supervise workflow and care practices to ensure that staff are facilitated to provide high quality, safe and effective care to all the residents in the hospital. A member of the management team will always be rostered at weekends to ensure the consistent delivery of person-centred care, including the provision of a variety of interesting and meaningful activities, based on the expressed preferences of residents. An experienced nurse will be identified on the roster to take charge of the hospital at night and this staff member will be responsible for maintaining a safe environment on night duty.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development: There are now 3 CNMs in post, including 2 recently appointed CNMs. 1 of the new CNMs is an experienced nurse who has been working as a Staff Nurse in the hospital until her promotion and the other is new to the hospital. Both newly appointed CNMs have completed an induction programme, supported by the PIC and ADON. Recruitment is ongoing to fill the remaining CNM positions and the ADON is supporting the supervision of staff and care delivery. The PIC is supporting the induction and performance of the management team with support from the Healthcare Manager (HCM). The ADON and General Services Manager (GSM) are being well directed and closely supported and their development needs are being addressed. There is a weekly management meeting to assess progress and identify development needs and service priorities. The PIC and management team will seek to develop the skills and expertise of nurses with a specific interest in certain clinical practices, such as IPC, Nutrition, Wound Care to ensure that there is a strong focus on current evidence-based practice. This will be a longer-term objective and progress will be reviewed by 31/12/2021.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A new electronic resident record system has been introduced, resident data has been entered and a significant amount of time has been spent in ensuring that staff have been trained how to use the system for recording assessment, care plans and all resident information. The PIC and key staff members already familiar with the system will provide guidance and coaching to nursing staff to ensure a smooth transition to the new system of record-keeping. Discussion on accurate documentation will take place at all handovers and safety pauses to ensure that staff are competent and confident with these requirements and are maintaining a high standard of clinical records. All Schedule 5 policies are now up to date and readily accessible to guide staff in all aspects of care.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC is being supported by the Healthcare Manager and the Director of Care Services in the achievement of all required objectives and in ensuring that there are safe, high quality systems of governance and management in place. Key Performance Indicators and operational issues in the home are recorded and reviewed on a weekly basis by this senior management team to ensure sustainability of progress, to identify areas in need of improvement and take corrective actions if required.

• There is a monthly management team meeting in the home which reviews all operational aspects of the home, including key performance indicators, risk management, audits and progress on identified actions and updates on quality improvement initiatives. This meeting is well attended and includes at least one representative from each department.
• An electronic resident record has been introduced which will enable improved record-keeping.
• We have reviewed the way in which audits are conducted in the home to ensure that there is an accurate assessment of areas that are not compliant with expected standards and that an action plan is devised, implemented and evaluated to ensure regulatory compliance and improve standards.
• The electronic risk register will be reviewed and updated regularly to ensure that identified risks are mitigated and appropriate actions taken to minimise and manage risks.
• The policies and procedures have been reviewed and are up to date and easily accessible to staff and management in the hospital.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC and management team will promote a culture of openness and transparency, including encouraging feedback from residents and relatives, whether positive or negative.
• Management and staff in the home are now actively engaging with and involving residents and/or their representatives regarding their views and preferences about

individual care or the overall service and quality of life in the hospital.
• All staff are encouraged to report and record all concerns and complaints at the earliest convenience, so that they can be resolved at a local level where possible.
• There are guiding policies available in relation to resident communication, consultation, concerns and complaints.
• The home has welcomed any suggestions and complaints from residents, relative/representatives and visitors. All comments or complaints are viewed as an opportunity to inform our service provision and they help us to continually improve the quality of care and service provided to the resident.
• The PIC and management team in the hospital will seek to resolve every complaint as early as possible and ideally at the first point of contact.
• The PIC will be supported by senior management to investigate all complaints thoroughly and to ensure that a comprehensive response is provided to ensure that complainants are satisfied that all aspects of their complaint were addressed.
• Complaints are managed in accordance with the Complaints Policy in the home and are discussed at the monthly Management meeting.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The PIC will:
• Implement the colour coding system for cleaning and disinfection.
• Conduct daily walkaround of the building with ADON/GSM to monitor standards of cleaning and identify any deficits to the Housekeeping Supervisor.
• Develop and implement a quality improvement plan to address any identified deficits.
• Facilitate safe cleaning practices and procedures for housekeeping staff.
• Review/update cleaning schedules and GSM will monitor adherence and compliance.
• Ensure that all household staff are trained in appropriate cleaning techniques and procedures by completing a Clean Pass programme.
• Monitor appropriate IPC practices, including Covid-19 prevention measures such as staff social distancing and mask-wearing.

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:
The PIC will complete a weekly audit of clinical documentation to ensure that each

resident's required care needs are addressed, that the care plan guides the delivery of care and that the care delivered is reviewed and evaluated appropriately and is in accordance with the resident's expressed preferences.

Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings.
Any changes or developments in the resident's condition or plan of care will be updated as they occur.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC will ensure the activity programme includes meaningful and purposeful activities that takes account of individual resident's interests, preferences and abilities, based on consultation with residents.

There will be activities scheduled seven days per week and all staff will be allocated time to be involved in social engagement with residents.

The Activities Coordinator will record individual resident's participation and preferences regarding activities in the resident's clinical record.

The Activities Coordinator will schedule time to provide a range of activities and will also arrange for entertainment and activities to be provided by external personnel as appropriate, including musicians and light entertainment, in accordance with HPSC visiting guidelines.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	31/05/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	31/05/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/05/2021
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	Substantially Compliant	Yellow	30/04/2021

	and are available for inspection by the Chief Inspector.			
Regulation 23(c)	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	Yellow	30/06/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	30/04/2021
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care	Substantially Compliant	Yellow	31/05/2021

	plan.			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Yellow	31/05/2021
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Yellow	30/04/2021
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	30/06/2021