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:	Tymon North Community Unit
Name of provider:	Health Service Executive
Address of centre:	Tymon North Road, Tallaght, Dublin 24
Type of inspection:	Unannounced
Date of inspection:	28 November 2023
Centre ID:	OSV-0007793
Fieldwork ID:	MON-0039803

About the designated centre

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

Tymon North Community Unit opened in March 2020. The centre can accommodate 48 residents, primarily for male and female dependent older persons, over the age of 18 years. The following categories of care are provided: Long-term residential and respite specific care needs catered, general nursing care, active elderly, frail elderly, dementia/Alzheimer's, physical disability, intellectual disability, psychiatry of old age, and general palliative care. There are three floors in Tymon North Community Unit, the ground floor accommodates the day care and other rooms, 1st Floor has two units namely Clover and Primrose and the second floor has two units named as Cherry blossom and Bluebell. and is located centrally with local services in reach, e.g. frequent bus routes, community centre, Tymon Park, local library shops and a pub is nearby. Tymon North Community Unit provides a residential setting wherein residents are cared for, supported and valued within a care environment that promotes the health and well being of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	42

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 28 November 2023	09:05hrs to 17:35hrs	Lisa Walsh	Lead
Tuesday 28 November 2023	09:05hrs to 17:35hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they liked living in the centre. Residents said the staff were "kind and good to them", and they were happy with the care received. Staff were aware of the residents' needs and strived to provide good quality care.

Inspectors arrived at the centre in the morning and were met by the assistant director of nursing in the absence of the person in charge. Following an introductory meeting, inspectors were guided on a tour of the centre. During the inspection, the inspectors spoke with several residents and their families to gain an insight into their lives in Tymon North Community Unit. The person in charge later attended the centre and met with inspectors. The inspectors also observed interactions between staff and residents and reviewed documentation.

Tymon North Community Unit is situated in Tallaght, Dublin 24, close to shops, a park and public transport routes. The centre occupies the ground and first floors of a three-storey building. The second floor is not part of the registered designated centre. The designated centre was accessed through a main entrance lobby on the ground floor that served all areas of the building. The ground floor accommodated the day centre, therapy areas, residents' facilities such as the reflection room, quiet room and snoezelen (sensory) room, administrative and archiving offices, storage facilities, laundry and waste management areas. On the day of inspection the reflection room, quiet room and snoezelen room were being used for staff break rooms and storage and not for use of the residents.

Resident bedrooms and living areas were accommodated on the first floor, which contained three units: Snowdrop, Primrose and Clover Units. The three units on the first floor have 40 single rooms and four shared twin bedrooms. All bedrooms had en-suite facilities containing a toilet, wash-hand basin and shower. The bedrooms also had televisions and call bell facilities. The centre is registered to accommodate 48 residents. On the day of inspection, there were 42 residents and six vacant beds. Inspectors were informed that two of these beds were being retained for isolation facilities in the event of an outbreak of infectious illness.

Inspectors noted the ground and first floors were bright, airy and pleasantly decorated for Christmas. It was observed that some areas of the centre, particularly on the ground floor of the premises, required attention to ensure it was safe and accessible for residents. These findings will be discussed further within the report under Regulations 17: Premises, 27: Infection control and 28: Fire precautions. The resident bedrooms and communal space on the first floor were clean and well-maintained. Resident bedrooms were personalised with photographs, teddies, books, knitting and other items of personal significance to them. The first floor's design and layout supported residents' free movement throughout, with wide corridors, sufficient handrails, armchair seating for residents and their visitors and

clear signage to communal areas.

Residents also had access to several outdoor courtyard areas. These courtyards had furniture, plants and decorative features. One of these areas outside the Snowdrop day room was a designated smoking shelter with a fire blanket, fire extinguisher and small ashtray. However, there was also a large empty food tin taped to the smoking shelter which residents were using to dispose of their cigarettes instead of the ashtray provided. This area also required call bell access for residents should they need assistance. The balcony area was also used for smoking by some residents, there was no call bell, fire safety equipment nor appropriate ashtray for residents to use. Inspectors also observed weeds growing and items of rubbish on the balcony that could cause a trip hazard to residents or fire risk with residents smoking in this area also.

Overall, residents stated they felt happy and safe living in the centre. Residents spoke positively about the staff that cared for them. The residents were also complimentary about the food on offer. Due to their clinical diagnosis, some residents could not speak with inspectors or give their views and feedback on the service. However, these residents were observed to be content and comfortable in their surroundings. On the day of inspection, staff were observed being respectful, caring and attentive to residents' needs. There was a relaxed atmosphere, and residents were observed freely mobilising around the first floor of the centre and chatting with other residents and staff.

Residents were neatly dressed and observed to be up and about in the various areas of the centre. Some residents were gathered together in the day rooms of the Snowdrop and Primrose Units having tea and biscuits while music played on a television in the background and staff sang along to the Christmas songs. Inspectors also observed residents painting Christmas decorations. Other residents had chosen to stay in their rooms or walk around their units at their leisure. Some residents were complimentary of the activities and proudly showed the inspector prizes won at bingo. However, three residents commented that the activities programme did not appeal to their interests. Residents could receive visitors in the centre in communal areas or in the privacy of their bedrooms. Inspectors also observed that from 5.30 pm, most residents were either lying on their bed or sitting in chairs at their bedside. Residents were no longer using the day rooms at this time.

The centre had two spacious dining rooms, and inspectors observed the lunchtime experience. Meals appeared nutritious and appetising. Menus were displayed on a large board and on each dining room table. There was a choice of meals being offered, as well as alternatives not on the menu and aligned with resident preferences. Residents who required assistance at mealtimes were observed to receive this support in a respectful and dignified manner. There was positive interaction noted at mealtimes and throughout the day between staff and residents. There were ample drinks available for residents at mealtimes and throughout the day. One resident was observed making a hot drink in one of the dining rooms. Residents commented positively about the quality and variety of food.

The next two sections of the report present the findings of this inspection in relation

to 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, inspectors found that improved supervision of staff practices were required in a number of areas to ensure the service provided to the residents upheld their rights and promoted their safety at all times. The management systems in place were not effective in ensuring the quality and safety of care provided to residents was safe and consistent. In particular, the systems in place with regard to oversight of premises, fire precautions, healthcare infection control, medication management, records, notification of incidents, complaints procedure, individual assessment and care planning, managing behaviour that is challenging, protection and residents rights.

On the day of inspection a number of immediate actions were issued by inspectors due to concerns, which included;

- Removal of a large commercial skip which was placed blocking a fire exit and access to the fire hydren.
- Removal of other items blocking fire exits, such as, chairs and bins.
- The reflection room, quiet room and snoezelen room to revert back to facilities for residents use.
- Removal of an unsecured oxygen tank which was left of the bed in an unlocked treatment room on the ground floor.

This was an unannounced inspection to monitor the ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013. The inspection also served to inform the provider's application to vary condition 1 of their registration, whereby the provider sought to change the purpose of a number of ground floor rooms to create additional storage and archiving space. The proposed changes also meant a change to the laundry flow, which was reviewed by inspectors on the day of the inspection and deemed consistent with the standards for the prevention and control of healthcare-associated infections.

The Health Service Executive (HSE) is the registered provider for Tymon North Community Unit. There was a clearly defined management structure with identified lines of accountability and responsibility. The person in charge worked four days a week in the centre and reported to the registered provider representative, the general manager for older person services. The general manager reported to the head of service and upwards to the chief officer. The person in charge was supported by two assistant directors of nursing, clinical nurse managers on each unit, staff nurses, health care assistants, activities coordinators, catering, household and portering staff.

Systems of communication were in place between the senior management in the centre and the general manager for older person services within HSE Community Healthcare Organisation (CHO) Area 7, including management meetings attended by providers of older persons' services in the area where matters such as incident and risk management, complaints, advocacy, infection prevention and control and data governance were discussed. Within the centre were staff meetings involving ward-based staff and nurse management professionals. These meetings discussed aspects of quality service delivery, including safeguarding, mandatory training, risk management and complaints.

There were sufficient staff resources on the day of inspection, however, the Person in Charge did not have access to allied health professionals required to ensure the effective delivery of care in accordance with their statement of purpose. The person in charge had made efforts to arrange alternative ways to access allied healthcare professionals by engaging staff via direct employment and recruitment agencies. However, the person in charge confirmed they could not access occupational therapy, speech and language therapy and dietitian services for residents who required these assessments and interventions.

While an audit schedule was in place, it needed to be sufficiently robust to identify areas of non-compliance with regulations, which will be discussed further under Regulation 23; Governance and management, 17; Premises and 28; Fire precautions. Some improvements were also required concerning the submission of notifications, which will be discussed under Regulation 31.

The registered provider had insurance in place to cover injury to residents. There was a well-maintained directory of residents living in the centre.

The provider clearly displayed the complaints procedure on the ground and first floors of the centre. There were leaflets on the complaints process and letterboxes available for the complaint to be submitted. The centre had an up-to-date policy guiding complaints management, and there were advertisements for advocacy services to support residents in making a complaint. The provider had records of how complaints had been managed in the centre. Residents said they could raise a complaint with any staff member. While staff were knowledgeable on the centre's complaints procedure, some improvements were required to fully comply with the regulation which is discussed under Regulation 34.

The inspector requested a sample of staff files. Evidence of identity, qualifications and references were held on file. The person in charge held professional registration and Garda vetting disclosures separately. While most Schedule 2 documentation was on file, there were gaps in employment histories, which will be discussed under Regulation 21.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The Chief Inspector received an application to vary condition 1 of the centre’s

registration. The application was under review on the day of inspection.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had a well-maintained directory of residents living in the centre, which included all the required information specified in Schedule 3 of the Regulations.

Judgment: Compliant

Regulation 21: Records

The inspectors reviewed three staff files. While most Schedule 2 documentation was on file, two files had gaps in employment histories.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had insurance in place via state indemnity confirmation statements, which covered injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Management systems required strengthening to ensure that the service provided was safe, appropriate, consistent, and effectively monitored. For example:

- The registered provider had not taken adequate precautions against the risk of fire and had not provided suitable building services for residents who smoke. The arrangements for extinguishing fires, for means of escape and for maintaining the building fabric were not adequate on the day of inspection. This is detailed in Regulation 28: Fire precautions.
- A number of rooms designated for residents usage were not being used in accordance with the statement of purpose. For example, the ground floor

reflection room was being used for storage. The ground floor snoezelen (sensory) and quiet rooms were being used by staff at mealtimes.

- Oversight systems for the submission of notifications to the Chief Inspector required review. Not all incidents required to be notified to the Chief Inspector were notified. This is detailed in Regulation 31: Notifications of incident.
- A number of areas in the centre required improvement in relation to infection control. For example, the first-floor store room contained clinical equipment used by residents, including wheelchairs, hoists and cushions. Staff were unclear if the equipment was clean or dirty, and there was no oversight system in place to monitor this. Some of the clinical equipment was visibly stained and contained food particles. The centre required a system to distinguish between clean and dirty equipment.
- The process for the review and management of residents' individual care needs, assessments and care plans required further oversight. For example, inspectors reviewed a sample of assessments and care plans and found that some care plans did not adequately describe the residents care needs. Furthermore, inspectors were informed that all female residents required a safeguarding care plan, however, three of the four care plan reviewed for female residents did not have a safeguarding plan in place.
- Since the previous inspection in December 2022 there had been considerable engagement with the registered provider following a safeguarding incident and the lack of supervision arrangements in place for staff. During this inspection the investigation was ongoing and appropriate supervision arrangements were now in place in relation to staff.
- The centre had undertaken medication audits in November 2023, which did not identify the expired vaccines found by inspectors nor reference the expired oral nutritional supplements that required prompt disposal.
- Furthermore, the centre had undertaken audits of restraints used in November 2023, which did not identify the environmental restraints in use within the centre, such as keypad door locks and window locks. The audits also did not identify specialised tilted seating as a restrictive practice.

While the registered provider had adequate nursing and carer resources to ensure effective nursing care, the residents required access to allied health professionals, specifically a dietitian, an occupational therapist and a speech and language therapist to ensure the effective delivery of care in accordance with the statement of purpose.

Judgment: Not compliant

Regulation 34: Complaints procedure

While the complaints procedure had been updated to align with S.I. No. 628 of 2022 - Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older

People) (Amendment) Regulations 2023, the following gaps were identified:

- The centre's complaints procedure referenced a review officer but had not nominated a named person to the role.
- The centre had comprehensively managed a formal complaint but had not issued the complainant with a written response as required under regulation.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Not all incidents required to be notified to the Chief Inspector were notified. For example, environment restraints within the centre, such as keypad door locks, window locks and specialised tilted seating, were not being notified as required.

Judgment: Substantially compliant

Quality and safety

While the inspectors observed kind and compassionate staff treating the residents with dignity and respect, the systems overseeing the service's quality and safety needed to be more robust and required significant improvement. Further action was required by the provider to come into compliance with the regulations, particularly concerning premises, fire safety, medication management, infection control, managing behaviour that is challenging, assessment and care planning, healthcare, protection and residents' rights.

A paper-based system of care planning and documentation was used by nursing staff. Validated assessment tools were used, and care plans were documented as being updated at four monthly intervals in line with regulations. However, gaps and discrepancies were observed in care planning, which impacted on the quality and care provided to residents. This is outlined under Regulation 5: Individual assessment and care plan.

Residents had access to medical, nursing and physiotherapy services within the centre. Despite efforts to recruit other allied health staff through direct employment and recruitment agencies, the registered provider could not provide access to specific allied health professional expertise. Residents losing weight and with specialist dietary requirements could not access a dietitian. Residents with dysphagia (swallowing difficulty) could not access speech and language therapy, except in emergency circumstances, via the local acute hospital services. Residents with specialist seating needs could not access an occupational therapist. This will be

discussed further under Regulation 6: Healthcare.

Restrictive practices required action as they were not always managed in accordance with the national restraint policy and guidelines. Records were reviewed of a small number of residents who were identified as having behaviours that challenge. ABC (antecedent, behaviour and consequence) charts were in place which noted incidents that had occurred and the management of the incident documented. In addition, behaviour care plans were in place. However, care delivery was not always adhering to this care plan and responded to in the least restrictive manner, which will be discussed further under Regulation 7.

The registered provider had taken measures to protect residents from abuse. Staff were knowledgeable about what constitutes abuse, the different types of abuse and how to report suspected abuse in the centre. The registered provider had a local policy aligned with the HSE's national safeguarding policy. The provider was a pension agent for seven residents. Records shown to inspectors confirmed residents' money was managed through a separate client account. However, further improvement in safeguarding planning was required, which will be outlined under Regulation 8.

Residents could receive visitors in the centre in communal areas or the privacy of their bedrooms. It was evident that visitors were welcome, and visitors and residents confirmed there were no restrictions on visiting. Residents had access to telephones, newspapers, televisions and free Internet services. There were arrangements in place for residents to access advocacy services. There were facilities for recreation and some opportunities to engage in activities. However, inspectors observed that there was limited activities offered with the majority of residents either in bed or in their rooms by 5.30pm. Some residents also voiced that the activities were not aligned with their interests and capabilities. Resident areas for quiet, reflection and sensory activity were being used for storage and staff mealtimes on the inspection day, meaning these facilities were available for residents to enjoy as outlined in the statement of purpose. Inspectors issued an immediate action to have the rooms reverted back to residents space on the day of inspection. This will be discussed under Regulation 9.

There were areas of good compliance observed on inspection. For example, the registered provider had an information guide available to residents and their loved ones, which contained information on the services and facilities, terms and conditions relating to residence in the centre, complaints procedure, arrangements for visits and information in relation to independent advocacy arrangements.

Residents were highly complimentary about the food, which was freshly prepared and cooked on site. Residents had access to fresh drinking water and other refreshments throughout the day. Residents had choices at mealtimes, and adequate supervision and assistance were available to those who required it. Staff were knowledgeable concerning residents' dietary requirements and preferences. Mealtimes were observed to be a sociable, relaxed experience.

While the design and layout of the first floor was appropriate to the number and

needs of the residents accommodated within the centre, rooms on the ground floor designated for resident usage were not being operated in accordance with the statement of purpose. These rooms had been designated for residents to partake in quiet, reflection and sensory sessions but were being used for storage or by staff at mealtimes, meaning they were unavailable for residents to enjoy. This will be discussed further under Regulation 17.

While the centre was generally clean on the day of inspection, a number of areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018), and this will be discussed under Regulation 27.

The oversight of fire safety management and systems to identify fire safety risks were not effective to ensure the safety of residents living in the centre. Significant fire safety risks were found, and inspectors issued immediate actions were taken by the provider to address those risks during the inspection. This will be discussed further under Regulation 28.

Inspectors were not assured that medicines were being stored and disposed of in accordance with professional guidance and the centre's medication management policy. This will be discussed under Regulation 29.

Regulation 17: Premises

Inspectors found that rooms on the ground floor of the premises, designated for resident usage, were not being operated in accordance with the statement of purpose. For example, the ground floor reflection room was being used for storage. The ground floor snoezelen (sensory) and quiet rooms were being used by staff at mealtimes.

The inspector found that the centre provided a premises which was mostly in conformance with Schedule 6 of the regulations, however, improvements were required for example:

- As outlined in the previous inspection report, storage issues throughout centre remained.
- Some ceiling tiles were missing in the waste recycling room.
- Improvement was required in relation to ventilation. For example, inspectors noted a strong odour within the laundry room.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents expressed overall satisfaction with food, snacks and drinks. Food was freshly prepared and cooked on site. Residents' dietary needs were met. There was adequate supervision and assistance at mealtimes. Choice was offered at all mealtimes, and adequate quantities of food and drinks were provided. Residents had access to fresh drinking water and other refreshments throughout the day.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared and made available a guide regarding the centre which included all the required information.

Judgment: Compliant

Regulation 27: Infection control

While the centre was generally clean on the day of inspection, a number of areas for improvement were identified to ensure compliance with the National Standards for Infection Prevention and Control in Community Services (2018):

- There was brown staining in the sluice sink within the first-floor dirty utility.
- There was brown staining and a used cup in the bath in the first-floor assisted bathroom used by residents.
- The first-floor store room contained clinical equipment used by residents, including wheelchairs, hoists and cushions. Staff were unclear if the equipment was clean or dirty, and there was no identifiable mechanism to determine this. Some of the clinical equipment was visibly stained and contained food particles. The centre required a system to distinguish between clean and dirty equipment. Storing clean and dirty clinical equipment together represents a risk of cross-contamination.
- Laundry baskets for resident clothing were observed to be in poor condition, requiring replacement. For example, some baskets were cracked, and some had large holes in the sides. This made them difficult to clean and posed a risk of residents' clean laundry falling out of the baskets.
- A crash mat used by residents was seen directly on the floor of the Primrose store room, meaning it was not possible to clean the floor.
- Inspectors found shared toiletry products in the ground floor treatment room, including roll-on deodorant and open packaging containing disposable pants. Sharing toiletries and open packaging presents a risk of cross-contamination.
- There was no records available for cleaning of equipment.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions against the risk of fire and had not provided suitable building services for residents who smoke.

- Two residents were using an undesignated outdoor smoking area at the front outside Clover Unit. As it was undesignated, there was no protective equipment for the residents in this area while they smoked, such as a smoking apron. In the event of a fire, there were no fire blankets or fire extinguishers in this area. There were no call bells for residents to summon assistance in an emergency. There was no suitable ashtray for the safe extinguishing of cigarettes.
- In the designated smoking area outside Snowdrop unit, residents had no call bell to summon assistance.
- On the ground floor at the fire exit by the boiler house staff were also using this area as an undesignated smoking area.
- Inspectors found domestic food tin cans being used as ashtrays in three outdoor areas: the residents undesignated smoking area, at a fire exit adjacent to the boiler house and in the designated smoking area taped to the smoking shelter.
- Six large-capacity plastic wheeled bins were located close to the side of the building. They were not secured to prevent unintentional movement. This presents a risk that if a fire starts in these large bins, it could spread to the designated centre. There was a secure enclosed area for these large bins, but inspectors were informed this area was being used by another service within the building, and this enclosed area was not available for the centre's bins.
- Flammable liquids and aerosols were located on trunking for electrical cables in the ICT Comms Room.
- An oxygen cylinder was found unsecured lying on its side on a plinth in the ground floor treatment room. Additionally, there was no signage on the treatment room door to alert people in the centre and the fire service to the presence of oxygen. Both matters were addressed on the day of the inspection.
- Oxygen cylinders were found in the Primrose store room, which was unlocked.
- No records of lint removal were available in the laundry to ensure the continued safe operation of laundry equipment.

The arrangements for extinguishing fires were not adequate on the day of inspection.

- Inspectors found an underground fire hydrant manhole obstructed by a commercial skip. An immediate action was issued by inspectors on the day of inspection to have this moved.

The arrangements for means of escape were not adequate:

- Inspectors found a fire exit obstructed by a dining chair, which would impede means of escape in an emergency. There was a large wheeled trolley on the corridor outside of the kitchen which was a fire escape route. The trolley narrowed the escape route, hindering egress if a fire evacuation was necessary.
- Domestic and clinical waste bins were observed directly outside the majority of resident bedroom doors, partially obstructing the exit in the event of an evacuation.

The arrangements for maintaining the building fabric were not adequate:

- There was a large hole in the ground of the boiler house, which had not been secured with fire-resistant sealing. Ceiling tiles were missing in the waste recycling room. Both issues present a risk of fire and smoke spreading from these areas to other parts of the centre in the event of a fire.
- The arrangements in place for evacuating residents were not adequate as the personal emergency evacuation plans were stored in a clinical room behind the nurses' station, meaning they were not readily accessible in an emergency to guide the safe evacuation of residents.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found expired vaccines located in a medication fridge next to in-date vaccines. The expired vaccines were not clearly labelled and identified as expired, posing a risk to residents of being used in error.

Inspectors found oral nutrition supplements that expired in September and October 2023 in the first-floor dry store. While the expired supplements were clearly labelled as expired they were not removed from the centre in a timely fashion, such expired medicines should have been disposed of immediately in accordance with the centre's own medication management policy.

Medicines requiring refrigeration according to their packaging and labelling were stored in a ground-floor refrigerator. However, the temperature of the fridge needed to be monitored in accordance with best practice. The ground floor medication fridge did not have daytime temperature checks completed 11 times in November 2023.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents were not able to access appropriate allied health care professionals for assessment. For example, a resident who was loosing weight had been referred to a dietitan, however, there is no dietitan services available for the resident to access.

There were also gaps and discrepancies noted in care planning found on this inspection. For example:

- A nutrition and hydration assessment had been completed for a resident, however, the care plan contained both the previous assessed needs which set out that the resident was independent to meet nutritional needs. The care plan also contained the residents changed needs following assessment which set out the resident needed assistance with nutrition. This was confusing and could lead to incorrect care being provided.
- Some care plans did not adequately describe the residents care needs and personal preferences in a detailed and person-centred manner required to guide staff to deliver effective, person-centred care. For example, the same safeguarding plan was used for several residents. Furthermore, following a previous safeguarding incident which was still under investigation, inspectors were informed that all female residents were required to have a safeguarding care plan. However, three of the four female residents records reviewed did not have a safeguarding plan.
- A resident diagnosed with diabetes who had foot care needs had no foot care plan nor a dietary care plan.

Judgment: Not compliant

Regulation 6: Health care

The Person in Charge did not have access to allied health professionals required to ensure the effective delivery of care in accordance with their statement of purpose. The person in charge had made efforts to arrange alternative ways to access allied healthcare professionals by engaging staff via direct employment and recruitment agencies. However, the person in charge confirmed they could not access occupational therapy, speech and language therapy and dietitian services for residents who required these assessments and interventions. The person in charge informed inspectors that residents with dysphagia (swallowing difficulty) could not access speech and language therapy, except in emergency circumstances, via the local acute hospital services. Residents with specialist seating needs could not access an occupational therapist. One resident observed in specialised tilted seating was last assessed by an occupational therapist in 2016, despite a referral for review submitted on the resident's behalf in 2021.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

A resident predisposed to episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) had a detailed responsive behaviour care plan. This person-centred care plan described the behaviours, potential triggers to such behaviours and identified strategies to support the resident. However, care delivery did not always adhere to this care plan. PRN medcines (medicines only taken as the need arises) was recorded as being used in four out of five instances in the previous six months without less restrictive alternatives such as, giving the resident space and other diversion therapeutic techniques, outlined in the care plan, being trialled first.

Additionally, the centre had not recognised specialised tilt-back seating as a restrictive practice and, therefore, was not using such restraints in accordance with national policy. Therefore, there were no restrictive practice assessments, care plans, risk assessments, review and release forms, or consent forms for using such seating.

Judgment: Not compliant

Regulation 9: Residents' rights

There were facilities for recreation and some opportunities to engage in activities. However, inspectors observed that there was limited activities offered on the day of inspection. Furthermore, the majority of residents were either in bed or in their rooms by 5.30pm. Feedback from some residents was that the more activities needed to be provided to ensure sufficient variety to appeal to the interests and capabilities of all residents.

Additionally, rooms allocated to residents usage were being used for storage and staff breaks so were not available to residents to use on the day of inspection. This included the residents quiet room, reflection room and snoezelen (sensory) room.

Judgment: Not 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	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tymon North Community Unit OSV-0007793

Inspection ID: MON-0039803

Date of inspection: 28/11/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: On the day of inspection the inspectors found that two staff files had gaps in their employment histories. Personnel files for all the staff in the unit are currently being reviewed and the employment history is being updated where required. Completion date for all files 29/02/2024.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An Operational Working Group has been set up to ensure that all the actions listed in this compliance plan are completed and that there are improvements in standards, compliance and governance in the unit. The group will be chaired by the PIC and supported by the Manager for Older Persons. The group will meet fortnightly initially and will have representation from staff in the unit, HSE Older Persons IPC Lead, HSE QSSI Older Persons Lead and HSE Estates staff. Unit audits including IPC, Health and Safety and Fire Safety audits will be reviewed at this meeting – Ongoing Daily health and safety walk arounds will be carried out by person in charge of the unit - 31/01/2024 Health and safety reps from the unit will carry out health and safety audits weekly initally and then monthly in the unit. The CHO Health and Safety Officer and Fire Officer will support this. These audits will be collated and reveiwed by the PIC and reported at monthly Operational Group meeting – Ongoing On the day of inspection the inspectors found that rooms on the ground floor of the premises were not being operated in accordance with the Statement of Purpose. These	

rooms have reverted to their use as per the Statement of Purpose – Complete

The unit IPC link nurses will carry out weekly IPC audits initially and then monthly on each unit. This will be supported by the CHO Older Persons IPC Lead. These audits will be collated and reveiwed by the PIC and reported at monthly Operational Group meeting - Ongoing.
A DON external to the unit has been temporarily reassigned to support nursing management with the care planning process. An initial audit of care plans has been completed and an improvement plan has been devised - Complete

There is a plan to re-introduce the DML care planning process will be re-introduced into the unit in line with the other CNUs in this CHO. The external DON will provide education on identifed improvements, implement a change process and then re-audit care plans in collaboration with nursing management. The process applied will be the 'Plan, Do, Check, Act (PDCA)' cycle. The underlying principle of this audit cycle is that this intervention is not complete until evaluation shows that there is an effective care planning process in place. Final review is planned for the 31/7/2024 - Ongoing
Following the inspection the safeguarding plans for the three female residents were found in the relevant resident's chart. However, they were mis-filed in the chart. The unit worked with the local HSE Safeguarding Team on all the safeguarding plans, which were personalised for each residents. The elements of the safeguarding plans were similar for all residents. A residential record working group is convened to address file management in CNUs in the CHO - Ongoing

Compliance to medication audit processes is being collated and reviewed reveiwed by the PIC and reported at monthly Operational Group meeting – Ongoing

A training programme on Restrictive Practice for staff is planned for the unit in Q1 to ensure that staff know the importance of identifiying restraint practices and adhere to the HIQA requirement for reporting of same - 31/03/2024

An audit on the submission of notifications will be carried out by the PIC in the unit on a quarterly basis to review compliance. This will be reported at the Operational Group meeting -31/04/2024

The restrictive practice audit will be reviewed and include keypad doors, window locks and non prescribed specialisied tilted seating on the checklist -31/01/2024
The Unit has a HSE Physiotherapy and Dietetic Service in place. However, the Dietitian is currently on leave. The Unit has contracted private Occupational Therapy, Dietetics and Speech and Language Therapy to support the delivery of these services – Ongoing

Activity staff to conduct monthly surveys and reviews of residents wishes which will include evening activities – 31/01/2024
PIC on unit to review and report on activity data at the Operational Team meeting – 29/02/2024

Spot checks will be carried out by Registered Provider, PIC, Manager for Older Persons, Business Manager, Maintenance staff and ADONs to ensure all issues identified in this report are being adhered to – Ongoing

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The complaints procedure has been amended to include the name of the review officer for the unit - Complete
A written response was issued to the complainant from the formal complaint referenced in this inspection findings - Complete

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
On the day of inspection the inspectors found that not all incidents relating to restraint which are required to be notified to the Chief Inspector were notified. All notifications pertaining to restraint will be included in the current quarterly report to the Chief Inspector which is due to be submitted on 31/01/2024

A training programme on Restrictive Practice for staff is planned for the unit in Q1 to ensure that staff know the importance of identifiying restraint practices and adhere to the HIQA requirement for reporting of same - 31/03/2024

An audit on the submission of notifications will be carried out by the PIC in the unit on a quarterly basis to review compliance. This will be reported at the Operational Group meeting -31/04/2024

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
On the day of inspection the inspectors found that rooms on the ground floor of the premises were not being operated in accordance with the Statement of Purpose. These rooms have reverted to their use as per the Statement of Purpose – Complete
Storage issues are being addressed by the removal of unused equipment – Complete

The options for the creation of additional storage space is currently being scoped out with HSE Estates -31/05/2024

Ceiling tiles that were missing in the waste recycling room will be replaced -31/01/2024.

A full review of the ventilation system will be carried out by HSE Maintenace Department -20/02/2024
All necessary repairs will then be actioned for completion pending the outcome of this review.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
The staining in the sluice sink in the first floor dirty utility room was cleaned immediately on the day of inspection - Complete
The staining in the first floor assisted bathroom was cleaned immediately on the day of inspection - Complete
A review of the cleaning schedules for the unit has been completed - Complete.
A monthly cleaning audit will be implemented in the unit supported by weekly checks by the cleaning supervisor and the outcomes will be reported through the Operational Group meetings - Ongoing
A system has been put in place for staff to identify clean and dirty equipment - Complete

Equipment cleaning records are now in place and will be reviewed as part of the IPC audits to be carried out by the unit IPC link nurses - Ongoing

Laundry baskets for resident clothing have been replaced - Complete

The crash mat in the Primrose Store Room was removed to appropriate storage - Complete

Shared toiletry products in the ground floor treatment room were removed and disposed of on the day of the inspection - Complete

Staff were given instruction regarding the non-sharing of toiletries on the day of inspection - Completed

The unit IPC link nurses will carry out weekly IPC audits initially and then monthly on each unit. This will be supported by the CHO Older Persons IPC Lead. These audits will be collated and reveiwed by the PIC and reported at monthly Operational Group meeting - Ongoing.
The CHO Older Persons IPC Lead will provide IPC training for all staff – 31/03/2024

The CHO IPC Team has have developed new resources for equipment cleaning in CNUs. Tymon North Community Unit has been identified as a pilot site for the new resources and staff training - 30/06/2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Two residents are using an undesignated outdoor smoking area outside the Clover Unit and refuse to use the other designated smoking areas in the unit. This area now has fire extinguishers, a smoking apron, a metal bin and a call bell in place. The unit is working with HSE Estates and the HSE Fire Officer to review this area to support the residents will and preference – 31/3/2024

The call bell is in place in the designated smoking area in the Snowdrop Unit - Complete

All domestic food cans have been disposed of from the smoking areas - Complete

Metal smoking bins are in situ in all the identified smoking areas - Complete

Older Persons Services are working with Health and Well-Being Smoking Cessation Officer to support staff who would like to quit smoking and to work towards a smoke free campus – OngoingAll staff have been instructed to smoke in designated smoking areas only - Complete

HSE Maintenance are planning a new enclosed outside area for the six large-capacity plastic wheeled bins - 30/06/2024

Flammable liquids and aerosols were removed from ICT comms room on day of inspection - Complete

The oxygen cylinder was secured in the ground floor treatment room on day of inspection – Complete

Signage was placed on the ground floor treatment room on the day of inspection – Complete

Oxygen cylinders are now in locked presses in the Primrose store room - Complete

To ensure the safe operation of the laundry equipment, the documentation process for the removal of lint has recommenced in the laundry - Complete
Compliance to this will be reviewed as part of the unit heath and safety audit – Ongoing
A commercial skip obtructing an underground fire hydrant manhole was moved on day of inspection – Complete
All fire exit obstructions were removed on day of inspection - Complete

Daily health and safety walk arounds will be carried out by person in charge of the unit - 31/01/2024
Health and safety reps from the unit will carry out health and safety audits weekly initally and then monthly in the unit. The CHO Health and Safety Officer and Fire Officer will support this. These audits will be collated and reveiwed by the PIC and reported at monthly Operational Group meeting – Ongoing
All Health and Safety Unit reps will receive fire training - 29/2/2024
HSE Maintenance and the HSE Fire Officer will review and repair the hole in the floor of the boiler house - 31/01/2024

Ceiling tiles that were missing in the waste recycling room will be replaced -31/01/2024.
Resident PEEPs will be placed in resident rooms so that they are readily available if evacuation is required - 29/02/2024

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Expired vaccines located in a medication fridge were disposed of on the day of the inspection - Complete

Expired oral nutrition supplements were disposed off – Complete
All medicines requiring refrigeration are now placed in the fridges on each ward – Complete

Compliance to medication audit processes is being collated and reviewed reveiwed by the PIC and reported at monthly Operational Group meeting - Ongoing

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 gaps identified in individual care-plans on the day of inspection have been rectified and updated - Complete
A DON external to the unit has been temporarily reassigned to support nursing management with the care planning process. An initial audit of care plans has been completed and an improvement plan has been devised - Complete

There is a plan to re-introduce the DML care planning process will be re-introduced into the unit in line with the other CNUs in this CHO. The external DON will provide education on identifed improvements, implement a change process and then re-audit care plans in collaboration with nursing management. The process applied will be the 'Plan, Do, Check, Act (PDCA)' cycle. The underlying principle of this audit cycle is that this intervention is not complete until evaluation shows that there is an effective care planning process in place. Final review is planned for the 31/7/2024 – Ongoing

Following the inspection the safeguarding plans for the three female residents were found in the relevant resident's chart. However, they were mis-filed in the chart. The unit worked with the local HSE Safeguarding Team on all the safeguarding plans, which were personalised for each residents. The elements of the safeguarding plans were similar for all residents. A residential record working group is convened to address file management in CNUs in the CHO - Ongoing

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Unit has a HSE Physiotherapy and Dietetic Service in place. However, the Dietitian is currently on leave. The Unit has contracted private Occupational Therapy, Dietetics and Speech and Language Therapy to support the delivery of these services - Ongoing

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The care plan for a resident to manage responsive behaviours was recorded on the ABC chart. However, this was not transferred to the narrative notes. This has been rectified and this change has been advised to all staff- Complete
The unit will report if a tilt back chair is used without OT recommendation to the Chief inspector as a restrictive practice in the quarterly report -31/01/2024
The restrictive practice audit will be reviewed and include keypad doors, window locks and non prescribed specialisied tilted seating on the checklist -31/01/2024
A training programme on Restrictive Practice for staff is planned for the unit in Q1 to ensure that staff know the importance of identifiying restraint practices and adhere to the HIQA requirement for reporting of same - 31/03/2024

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All residents have an individual activity care plan informed by the residents' will and preferance and this is reviewed on a regular basis - Ongoing
Activity staff to conduct monthly surveys and reviews of residents wishes which will include evening activities – 31/01/2024
PIC on unit to review and report on same at the Operational Team meeting – 29/02/2024
On the day of inspection the inspectors found that rooms on the ground floor of the premises were not being operated in accordance with the Statement of Purpose. These rooms have reverted to their use as per the Statement of Purpose – Complete

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	28/11/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/11/2023
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Substantially Compliant	Yellow	29/02/2024

	designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/01/2024
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	Orange	29/02/2024
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	31/03/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of	Not Compliant	Orange	30/06/2024

	fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	01/12/2023
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.	Substantially Compliant	Yellow	30/06/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2024
Regulation 29(6)	The person in charge shall ensure that a medicinal product which is out of date or has been dispensed to a resident but is no longer required by that resident shall be stored in a secure manner, segregated from other medicinal products and disposed of in accordance with national legislation	Substantially Compliant	Yellow	31/01/2024

	or guidance in a manner that will not cause danger to public health or risk to the environment and will ensure that the product concerned can no longer be used as a medicinal product.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	30/04/2024
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Substantially Compliant	Yellow	31/01/2024
Regulation 34(2)(d)	The registered provider shall ensure that the complaints procedure provides for the nomination of a review officer to review, at the	Substantially Compliant	Yellow	31/01/2024

	request of a complainant, the decision referred to at paragraph (c).			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/01/2024
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	Orange	31/07/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/07/2024
Regulation 6(1)	The registered provider shall, having regard to	Not Compliant	Orange	29/02/2024

	the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Not Compliant	Orange	31/03/2024
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	31/03/2024
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other	Not Compliant	Orange	31/01/2024

	persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.			
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	31/03/2024
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/01/2024
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	29/02/2024