Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Craddock House Nursing Home
Name of provider:	Werlay Limited
Address of centre:	Craddockstown Road, Naas, Kildare
Type of inspection:	Unannounced
Date of inspection:	28 March 2024
Centre ID:	OSV-0000027
Fieldwork ID:	MON-0043234

About the designated centre

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

Craddock House Nursing Home is purpose-built and was established in 1999. It is located on the outskirts of Naas town, close to the general hospital and across from a secondary school. Residents have good access to amenities and have a range of recreational activities within a warm, welcoming and friendly atmosphere. There is unrestricted access to colourfully planted, paved and secure courtyards with open and sheltered seating areas along with many tactile items, including water features. The large courtyard garden has covered seating. There is a small courtyard garden off Rose Cottage and two other garden areas for resident use. The nursing home provides 24-hour nursing care seven days per week and is designed to ensure the comfort and safety of residents in a home-like environment. The nursing home provides a respite service, residential and convalescent care. Male and female residents are primarily over 65 years of age. The home can accommodate 89 residents over two floors serviced by a passenger lift and stairwells. It comprises 77 single and six double/twin bedrooms. Most bedrooms have full en-suite facilities or shared bathrooms, and nine single bedrooms that have access to communal toilet and bathroom facilities within close proximity. There are three main day and dining areas, called The snug, The cosy corner and The relaxation room. There are two conservatories and a spacious reception area for residents to relax in. In addition to these, there are two administration offices and three nurses stations, a hairdressing salon that operates three days weekly, a spacious oratory where mass is celebrated weekly, the main kitchen that services the households and a spacious multi-purpose room for family functions, meetings and staff training. Separate and adjacent to the main building are the laundry, boiler room and additional administration offices. To the front of the building, there are ample car parking spaces.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	86

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
Thursday 28 March 2024	09:40hrs to 17:30hrs	Aislinn Kenny	Lead
Tuesday 16 April 2024	10:00hrs to 18:25hrs	Aislinn Kenny	Lead
Tuesday 16 April 2024	10:00hrs to 18:25hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This inspection was conducted over two separate days. The inspectors spent time in the centre to see what it was like for residents living there. Throughout the days of inspection, the inspectors spoke with many residents and with approximately ten residents in more detail. Residents told the inspectors they felt safe in the centre and one resident said 'staff are great and will do anything for you'. Another resident told the inspectors 'I have plenty to do and am well looked after.' Three residents described having to wait at times for assistance from staff. Other residents, due to speech or cognitive impairment, were unable to elicit their opinion on the service being provided in the centre; however, they appeared happy and content in their interactions. Inspectors observed that although the residents were well cared for by staff, significant improvements were required to ensure the safety of the residents and compliance with the regulations which will be discussed further in the report.

During the first day of the inspection the inspector observed immediate and urgent risks in relation to Regulation 28: Fire Precautions and that many areas of the premises were not well-maintained and significant action was required to ensure the environment was appropriate to meet the needs of the residents. For example, the inspector observed that access to outdoor space was obstructed with signage up informing residents it was not to be used due to maintenance work required on uneven surfaces. However, there was no plan in place to address this. The inspector also observed inappropriate storage in the attic space which posed a fire risk and various items of broken equipment, unused storage units and past residents' clothing were being stored along the first floor corridor under the windows. A bed was observed stored in the Oratory, thus obstructing a space that should be available for residents' use. The provider was responsive to the findings of the inspection and good improvements were observed by the second day of inspection. However further risks were identified in relation to fire safety which resulted in another immediate action on the day to mitigate the risks. These details are presented under Regulation 23: Governance and Management and Regulation 28: Fire Precautions. The centre is a two storey building with most residents' bedrooms contained on the ground floor and a lift available to the first floor. There are twelve bedrooms located on the first floor with 11 residents accommodated on this floor on the day of inspection. One of these residents had greater dependency needs in respect of evacuation and consideration was required to ensure staff had the capacity and ability to safely evacuate all residents in the event of fire. On the ground floor there was a welcoming entrance hall where visitors signed in.

The reception area was large and nicely decorated and the inspectors observed visitors sitting and spending time in this area on the day of inspection. The ground floor area was divided into two households Rose Cottage and Lily Valley. There were large communal areas on the ground floor where residents were observed resting and engaging in activities with staff. The centre had a courtyard garden also on the ground floor which could be accessed freely by the residents and visitors through both conservatories on the ground floor. The centre was generally clean, however

on the first day of inspection there were areas that required attention in two sluice rooms, where clean items were observed stored alongside dirty items. This issue was not fully addressed by the second day of inspection, as a trolley containing residents' clean towels and clean sheets was found in one of the sluice rooms. Inspectors also observed a small number of insects in one area and assurances were received following the inspection that appropriate pest control measures had been put in place. Additional findings in respect of infection prevention and control are presented under Regulation 27.

Residents' rooms were well-maintained and all residents spoken with were happy with their rooms. There were areas of the building observed in need of maintenance, in particular the first floor flooring, which felt bouncy and unstable in certain areas outside residents' rooms. The inspector was informed that the provider had replaced the flooring throughout the ground floor and there was a plan in place to replace the upstairs flooring also. By the second day of inspection, the inspectors observed improvements and some areas of the flooring had been replaced. The inspectors were informed that a leak had been identified to have caused the damage in one of the areas and the provider committed to provide further assurance in the form of a structural integrity assessment report.

The following two sections, capacity and capability and quality and safety will outline the quality of the care and services provided for the residents. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

The oversight arrangements in the centre were not sufficient to proactively identify, respond to and manage significant issues in respect of fire safety and premises. An urgent action was given to the registered provider following the first day of inspection in respect of significant concerns identified. While most of these actions were addressed following the first day of inspection there were further findings also requiring immediate and urgent attention on day two, which are discussed further in the report. Consequently, the inspectors were not fully assured of the governance and management arrangements and that there were sufficient and appropriate systems in place to ensure the service provided was safe, appropriate, consistent and effectively monitored.

This was a two day unannounced inspection carried out by inspectors of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) taking place within a period of two weeks. Overall, the centre had a good regulatory history however, this inspection found significant decline and action was now

required by the registered provider to ensure a safe and high-quality service was consistently provided to the residents living in the designated centre.

Werlay Limited is the registered provider of Craddock House Nursing Home, which is part of the Virtue Integrated Care Group. The centre had a full-time person in charge who was supported in their role by an assistant director of nursing, clinical nurse managers, a team of nursing staff, care staff, housekeeping, catering, administrative and maintenance staff. The person in charge reported to a senior person participating in the management of the designated centre in the role of Project Manager and the registered provider. Although this inspection found that there were governance and management structures in place, improved oversight by the provider was necessary to ensure the effective and safe delivery of care in accordance with the centre's statement of purpose. Insufficient oversight of staff practices resulted in the failure to recognise and report risks associated with fire safety and care planning as evidenced further in this report.

There were systems in place to monitor the quality and safety of the service, such as monitoring of staff training and audits for wound care, nutrition, falls analysis and medication management. However, there were no records available in relation to weekly fire alarm tests or health and safety walkabouts. Furthermore, some of the audits on the schedule were not completed in line with the schedule including a six monthly fire safety audit and some audits presented to the inspectors had no agreed action plan on how to deliver improvements in place. Inspectors found on the second day of inspection a schedule had been put in place to implement weekly health and safety audits and a weekly storage check. There was evidence also that a review of care plans had taken place and was ongoing following the findings of day one. The signage had been removed and residents had access to the garden. The inspectors were informed there was work scheduled to address the uneven surfaces in the garden, which were cordoned off to prevent any trips or falls.

The provider had arranged for a fire safety risk assessment, which was last reviewed in May 2023 and was due for review in May 2024. The provider had an action plan in place to address the findings of this risk assessment. There was a risk relating to fire containment to the dining room, which requires further review and this is detailed further under Regulation 28. The inspectors reviewed written policies and procedures and found that they were compliant with the legislative requirements, however deficits in staff supervision and oversight meant that these policies were not consistently implemented in practice.

Regulation 23: Governance and management

The provider's management systems required significant action to ensure that the service provided was safe, appropriate and effectively monitored. For example:

- The management systems to provide assurance in respect of fire safety were insufficient. Oversight of the fire safety measures in the centre to ensure emergency escape routes were kept clear of obstruction at all times was not

effective. An immediate action plan to remove all obstructions from key areas was issued to the provider on the evening of the first day of the inspection. A second immediate action was issued on the second day of inspection to remove combustible storage from the electrical room.

- Resident access to a courtyard had been restricted, there was signage up to prevent residents from using the garden area due to uneven surfaces however, there was no evidence of a plan in place to address this and the door to the courtyard was marked as a fire exit and means of escape. This was addressed by the second day and residents had free access to the garden area.
- There were no clinical hand wash sinks installed close to the point of care despite confirmation by management that they had been ordered and were available on site for three months.
- Clinical governance arrangements were not sufficient to ensure effective oversight of residents' care planning arrangements including that relevant care records were not maintained when a resident was temporarily absent or discharged. This issue had not been identified by provider's own auditing systems
- While staff had received training in key areas such as fire safety and infection prevention and control inspectors were not assured that staff were appropriately supervised to ensure that the local policies and the principles of training were implemented in practice.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Contacts for the provision of care were viewed and contained details of the service provided and any fees associated with this service

Judgment: Compliant

Regulation 31: Notification of incidents

The Chief Inspector was notified about incidents in the designated centre as set out in Schedule 4 of the Health Act 2007 (Care and welfare of residents in designated centres for older people) Regulations 2013.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations, however inspectors were not assured these were being implemented in practice. For example; the fire safety policy set out the responsibility for having suitable arrangements to ensure adequate staff and evacuation aids are available for all residents and these were not in place.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found significant deterioration in the quality and safety of the service provided and notwithstanding the positive feedback reported by the residents in respect of their quality of life, there was a lack of assurance in respect of the standard of care they received from a review of the supportive documentation and residents' care records. Significant improvements were now required in several areas, specifically fire precautions, premises, infection prevention and control and residents' care plans to ensure that the care provided was safe and appropriate at all times.

Inspectors reviewed fire safety precautions and found that the registered provider had failed to identify significant fire safety risks in the centre, which required immediate and urgent action. Specifically, significant concerns were found in respect of fire and smoke containment, maintaining of escape routes, evacuation procedures to ensure that all residents could be safely evacuated to a place of safety in the event of fire. There was a lack of clarity regarding fire compartment boundaries in some areas; the fire doors within some of those compartment boundaries did not meet the required fire rating of the wall. The inspector reviewed the attic spaces on the second day of inspection and found they were clear of storage and saw evidence that a fire sealing specialist contractor had sealed each of the fire compartment and sub-compartment walls.

Significant action was required in respect of premises in order to come into compliance with the regulation. Inappropriate storage arrangements were observed in the centre with residents' personal items stored in communal areas and items such as suitcases and furniture stored on corridors. The first floor flooring was unstable and felt spongy and required review. There was maintenance required in some areas of the centre to ensure the premises was kept in a good state of repair, in particular maintenance was needed in the hair salon skirting areas and the sluice room flooring. This is discussed further under the relevant regulation.

Care plans were available for all residents, however, reviews were not carried out at four monthly intervals or sooner if required, and inspectors therefore were not

assured that residents were receiving the highest standard of evidence-based nursing care. Details of issues identified are set out under Regulation 5: Individual assessment and care plan. End-of-life care plans were not in place for all residents, a sample reviewed found that there were no such care plans in place for three residents to support them at the end of life. A review of residents' care plans on the second day of inspection found an improvement had been made in this area.

Temporary absence and discharge arrangements were in place in the centre however transfer documents or records were not available for three residents who had recently been in hospital. This was put in place by the second day of inspection.

A resident's account and personal property policy was in place and there were arrangements in place to support residents' access to personal belongings and finances, which was effectively monitored by the provider. The inspectors were informed that the provider was not acting in the capacity of a pension-agent for any residents living in the centre.

Regulation 13: End of life

From a sample of care plans reviewed the inspector found gaps in the arrangements in place for the provision of appropriate care and support at the end of life. The person in charge had not ensured that all residents had an appropriate end-of life care plan that reflected their individual physical, emotional, social, psychological and spiritual needs and ensured that their needs were met.

Judgment: Substantially compliant

Regulation 17: Premises

The registered provider did not ensure that the premises were appropriate to the number and needs of the residents of the designated centre and in accordance with the statement of purpose prepared under Regulation 3. For example;

- A bed was being stored in the Oratory, which is a dedicated space for reflection and spiritual needs
- There was a storage area under a stairway being used as an office, which did not align with the registered floor plans or statement of purpose

Many aspects of the premises did not conform to the matters set out in Schedule 6 of the regulations. For example:

- There were inappropriate storage arrangements throughout the centre for example; some personal items belonging to residents were stored in communal areas, there was a large amount of furniture and broken items contained in the rear yard this included trolleys, walking frames, bins, broken furniture and tray tables.
- Broken unused equipment, unused storage units and past resident's clothing were being stored along the first floor corridor under the windows.
- Handrails were only fitted to one side of the stairway identified for residents to circulate between floors, and not on both sides as required
- There were concerns over the stability of parts of the floor construction at first floor as it felt unsteady to walk on
- There were electrical wires stored on top of the generator which posed a safety risk
- Privacy arrangements required review, there was no privacy curtain in place in one of the twin rooms on the first day of inspection, this was in place by the second day
- The water in a bathroom sink was too hot. This was addressed during the inspection. Assurance is required that all have been checked to ensure the water is maintained within safe temperature limits

Maintenance was required to keep the centre in a good state of repair internally and externally as evidenced by;

- Numerous doors and walls were observed to be damaged and scuffed from equipment and were in need of repair
- There was staining on the ceiling outside the drawing room
- The skirting board in the hairdresser room was coming away from the wall; it was damaged from a previous leak in this area and there was a damp odour
- There was a trip hazard where the corridor flooring met the flooring in the hairdresser room
- There was damage to the flooring in a sluice room
- The flooring of some en-suites, where it was carried up onto the wall was peeling
- The Chemical store had damaged walls and exposed plaster and were in need of repair
- Light fittings had been replaced throughout the centre; the ceilings had not been painted where the old lights had been removed which made it unsightly.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

Appropriate arrangements were not in place to ensure that when a person was transferred or discharged from the designated centre, their specific care needs were appropriately documented and communicated to ensure resident's safety. Inspectors found a number of residents who had recently been temporarily absent had no transfer form recorded. Inspectors were told this was due to a computer system error. This was addressed by the second day of inspection and there were records available for the inspector to review and evidence that all information had been appropriately documented.

Judgment: Not compliant

Regulation 27: Infection control

The inspectors were not assured that procedures consistent with the *National standards for infection prevention and control in community services (2018)* were consistently and effectively implemented and that the environment was managed in a way that minimised the risk of transmitting a healthcare-associated infection.

This was evidenced by;

- Inspectors observed a failure to segregate function areas within the centre. For example; a residents' laundry basket was found in the sluice room and there were items such as bed pans and commode pails labelled as 'decontaminated items for storage' and being stored in a plastic box in the sluice room with the lid open
- There were insects observed in the sluice room and an area of the floor covering in the sluice room had lifted, not ensuring the floor could be sufficiently cleaned.
- The environment had not been cleaned to an acceptable standard. For example the kitchenette in the drawing room was dirty and required a deep clean;
- Residents' equipment such as wheelchairs were visibly unclean. In addition, there were dirty commodes observed on the second day of inspection
- Hand hygiene facilities were not in line with best practice and national guidelines. There was a limited number of dedicated hand wash sinks in the centre and clinical hand washing sinks of appropriate specifications had not been installed.
- There was no hand wash sink in the clinical room in Rose Cottage

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors were not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire.

On the first day of inspection, the provider was issued with immediate actions and was required to submit an urgent compliance plan to address urgent risks, including inadequate arrangements for evacuation of residents from the upper floor, obstructed exits, poor storage practices in attics and stairwells and inappropriate smoking arrangements for staff. This created a risk to the safety of residents. The provider’s response did provide assurance that the risk was adequately addressed.

Fire safety risks identified on the first day of inspection had been actioned by the second inspection day. Exits were being maintained clear, storage had been removed from the attic spaces, the staff smoking area was relocated to a more suitable location away from the generator and storage under the stairs and within stairwells had been removed.

Notwithstanding the actions taken since the first day of inspection, on the second day of inspection the provider was issued with further immediate actions and required to submit a second urgent compliance plan.

The Personal Emergency Evacuation plans (PEEP) for the residents on first floor and discussion at feedback identified that 11 residents required a ski pad for evacuation, however there were only eight available at first floor. The fire door to the kitchen was propped open and there was combustible storage in the electrical room, an area of increased fire risk. Before the end of the inspection, the electrical room had been cleared out. The provider’s response did provide assurance that these risks were adequately addressed and confirmed that additional evacuation aids were in place on the night of inspection and the kitchen door was adjusted.

In addition to the above, the provider was not taking adequate precautions against the risk of fire, nor adequately reviewing fire precautions. Improvements were required in the day-to-day oversight of fire safety, for example:

- Over the course of both days, a number of fire doors were observed to be propped open, thus posing a risk of inadequate smoke and fire containment.
- Equipment batteries were being charged along escape corridors, introducing a fire risk to the protected escape corridors
- The residents' smoking shelter was located adjacent to a resident's bedroom window. There was no risk assessment in place to identify impact and controls.
- The force of some closing devices to bedroom doors was too strong posing a risk to a resident with restricted mobility or frailty.

There was inadequate containment and detection of fire, for example;

- The inspectors observed a number of fire doors that did not have the appropriate fire rating. There were a number of sixty minute fire-rated walls with thirty minute doors fitted; this did not align with the approved design of the building. This included fire compartment walls and walls enclosing the kitchen, a room of increased fire risk.
- The fire compartment door near room 43 did not appear to align with the position of the compartment wall in the attic; this required further investigation and assurance that the wall and door form a complete fire compartment boundary
- The wall between the rear dining room and the escape corridor did not provide adequate containment of fire. This was highlighted in the provider's own fire safety risk assessment
- A decommissioned lift shaft had been converted to a store at ground floor level; the walls and door to the protected escape corridor would not contain smoke
- There was a hole in the plasterboard of the wall of a fire compartment boundary, which impacted the effective fire containment of the wall from the staff area to the adjoining attic area housing the water tank
- There was a fire-rated roller shutter door to the window of a resident's bedroom. It was not known by staff how to operate it, if it would close automatically and if it required maintenance
- There were multiple penetrations through fire rated ceilings, including recessed lighting and mechanical ventilation vents. Assurance is required that the penetrations are appropriately sealed to maintain the fire rating of the ceiling
- A recessed area off the corridor, used for charging hoist batteries did not have a smoke detector
- There were a number of areas with timber sheeted ceilings. It could not be determined if these areas were appropriately treated to prevent the spread of fire. Assurance is required from the provider.

The arrangements in place for maintaining fire equipment, means of escape, building fabric and building services were not adequate, for example;

- The inspectors observed multiple deficits and lack of maintenance to a number fire rated door sets that required action. For example, door closers not in place, screws missing to hinges to securely hold door in place, smoke seals missing. There was a large gap beneath a fire compartment door. These deficits were impacting the fire containment measures in the centre
- The fire alarm and emergency lighting systems were overdue the quarterly test and service

The provider was not ensuring an adequate means of escape was provided, including emergency lighting, for example:

- The provision of escape signage was not adequate; for example some areas of the external escape routes did not have adequate coverage of emergency lighting to ensure safe escape to the assembly points

- The measures in place to safely evacuate residents and the drill practices in the centre required action. The inspectors reviewed fire drill records and found they did not contain sufficient information to demonstrate that the evacuation procedure was fit for purpose. The evacuation strategy had recently changed; evacuation mats were now in use in lieu of previously used ski sheet and mattress to address difficulty evacuating residents down the stairs. The inspectors saw just one record to simulate the use of the ski mats. Furthermore, evacuation chairs were located at each stairway, however staff had not been trained on how to use them.
- Assurance was required that evacuation aids in use, would fit through exits and could be manoeuvred along external escape routes. This had not been tested in evacuation drills or training. For example, an exit opened across an escape path and it was not known if evacuation aids could fit around the door and along the path.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident were assessed and an appropriate care plan is prepared to meet these needs. For example:

- Inspectors found that residents care plans were not always updated on a four monthly basis or sooner if there were changes in resident's condition
- Care plans for residents were generic and lacked person-centred detail
- Inspectors were not assured that care plans were specific to the individual resident as some residents were referred to by different names within their care plans
- A resident who returned from hospital following a fall did not have their care plan updated to reflect the change in their mobility and actively guide staff in the provision of care for this resident.
- Residents' care plans were not updated following safeguarding incidents that had been notified to the office of the Chief Inspector. This meant that staff may not be aware of the current protective measures to safeguard a resident
- Some residents, including residents identified as requiring palliative care did not have end of life care plans in place.

Judgment: Not compliant

Regulation 6: Health care

The inspectors found that the health care needs of residents were met, and they had access to appropriate medical and allied health care services

Judgment: Compliant

Regulation 8: Protection

Staff had completed safeguarding training and staff spoken with confirmed that they had the appropriate skills and knowledge on how to respond to allegations or incidents of abuse. The inspector found that all reasonable measures were taken to protect residents from financial abuse. Residents had lockable storage space in their bedrooms for their valuables. Appropriate systems were in place to ensure the transparent management of residents' personal finances

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence or discharge of residents	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Craddock House Nursing Home OSV-0000027

Inspection ID: MON-0043234

Date of inspection: 16/04/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Following day 1 of the inspection (28/03/2024) all items causing obstruction to evacuation routes were removed.
Completed: 28/03/2024
The electrical store room was cleared of all combustable items during day 2 of the inspection.
Completed: 16/04/2024
Staff meetings occurred on 02/04/2024 and 03/04/2024 with all staff to re iterate awareness in all areas of fire safety including ensuring all escape routes and fire doors are un-obstructed at all times. Minutes of these meetings were made available to the inspector on day 2 of the inspection.
Completed: 03/04/2024
A comprehensive Fire Safety Management audit was completed on 08/04/2024 by a competent person with a resulting Quality Improvement Plan to ensure sufficient oversight was in place for all fire safety measures. A member of the management team on duty each day is allocated the responsibility of completing the daily fire safety checks, including checking the fire escape routes and fire doors for obstructions, ensuring the fire extinguishers are functional, in their designated places and free from obstruction, within service dates, and verifying that all break-glass units are accessible and intact. The daily fire safety checks are documented, and all findings are reported to the Director of Nursing during the Daily Management team meetings and any urgent actions are completed without delay.
Completed: 29/03/2024
To further enhance the overall governance in relation to fire management safety, a designated member of the management team on duty completes and documents daily management quality assurance checklist to ensure the fire safety daily checks are completed and accurately recorded and any identified risk items are actioned immediately.
The senior management team are fully informed and have oversight of the weekly fire

system and fire door checks.
Completed: 02/04/2024
Any findings from daily and weekly fire safety checks, daily management quality assurance checklist and audit findings are discussed during the management daily meetings , weekly leadership meetings commenced on 26/04/24 and weekly Clinical and non-Clinical Governance meetings chaired by the Registered Provider Representative .
The Weekly Leadership meeting agenda includes a review of Fire Safety Management, Premises, Health & Safety and Infection Prevention and Control within Craddock House.
Completed: 26/04/2024
Additionally, a nominated member of the management team has oversight in Health and Safety and has completed Certified Health & Safety Representative Training.
A Health and Safety (H&S) Committee is in place with reviewed and updated Terms of Reference. The H&S committee now includes representation from all areas. Health and Safety meetings are scheduled monthly as part of Craddock House annual meeting plan, the last H&S committee meeting was held on 30/05/2024.
Completed: 26/04/2024
Following day 1 of the inspection only the uneven surfaces identified in the courtyard were cornered off, which facilitated access for all residents to other areas in the courtyard at all times including in the event of a fire and the signage was removed.
Completed 29/03/2024
The uneven surface in the courtyard has since been repaired and residents continue to have unrestricted access to this outdoor space.
Completed: 18/05/2024
Three clinical hand wash sinks in accordance with the required specifications have been installed since 22nd April 2024, including 1 clinical hand wash sink in Cherry Blossom Drawing room, 1 clinical handwash sink in Rose Cottage Parlour and 1clinical hand wash sink in the medication room in Lilly Valley.
Completed: 22/04/2024
The care planning and nursing documentation audit tool in use was reviewed following the inspection which now includes the completion and retention of the national transfer documentation when a resident is temporarily absent or discharged from Craddock House.
Completed: 01/06/2024
Following the inspection an analysis of the quality of the audit process was completed on all audits completed during Quarter1 of 2024 by the Project Manager on 08/04/2024, whose findings included the need for increased monitoring of the adherence of annual audit schedule. All members of the management team received Audit training with the responsibility for completion of audits and creating the resulting Quality Improvement plans including SMART objectives. A review was completed of audit tools in place and audit tools were updated to reflect the improvements required. A further audit analysis was completed by the Project Manager on 03/06/2024 to monitor compliance with the audit process in April and May.
Completed: 05/06/2024
The overall infection and prevention control Governance has been reviewed with the Infection and prevention Control committee now including representation from different staff areas. Since inspection IPC committee meetings have occurred on 25/04/2024, 24/05/2024, 30/05/2024 and 04/05/2024 and are now scheduled weekly. Meeting minutes are maintained.
Completed: 25/04/2024

A member of the management team in Craddock house is the designated Infection and Prevention control link practitioner and has completed certified IPC nurse practitioner training.
Completed: 17/05/2024
To strengthen the overall governance and management of Craddock House an additional Clinical Nurse Manager was recruited prior to the inspection and has commenced employment in Craddock House and has completed the revised Clinical Nurse Manager induction training which now includes completion of audit training and creation of Quality Improvement plans.
The management team are allocated overall responsibility of a House which includes the completion of audits, nursing documentation and care planning and staff supervision of delivery of care practices to residents on a daily basis.
The Project Manager attends on site in Craddock House two days per week to support the management team with the overall Governance and management of Craddock house whilst the Registered Provider Representative is also on site one day per week.

A daily Quality assurance checklist was implemented and is completed by the Management team daily, thus ensuring all policies and procedures and the principles of training are being adhered to ensuring a robust and pro-active approach to the overall governance of Craddock House .

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Following inspection an inventory was completed of all evacuation aids available for residents following a review of all current residents Personal Emergency Evacuation Plans . Three additional Ski mats were sourced and were in place on the 1st floor by the evening of day 2 of inspection on 16/04/2024 which was confirmed to the authority .The location of the additional ski mats has been included in the Fire Management inventory and communicated verbally to all staff.
Completed: 16/04/2024
A comprehensive fire safety management audit was completed following inspection on all areas of fire safety management as mentioned in Regulation 23 compliance plan.
Completed: 08/04/2024
As part of the Quality Improvement Plan, fire safety documentation was reviewed and updated to include the availablility, location and safe use of all evacuation equipment and this was communicated out to all staff which forms part of staff fire safety training.
Weekly fire drills have been completed since inspection to provide assurance that policy and procedures and principles of fire training are understood and being consistently practiced by all staff in Craddock House.
Completed and in place: 08/04/2024
Included in the daily management quality assurance checklist of resident personal

emergency evacuation plans are now in place and completed by the senior management team and any findings are promptly actioned and closed out. All residents personal emergency evacuation plans are audited as per schedule of audits . Completed: 30/05/2024 Residents changing needs are discussed in the management daily meetings which were initiated on 26/04/2024. This provides an enhanced oversight and a timely approach in ensuring individual resident evacuation equipment is in place as resident needs change. Minutes of the daily management meetings are maintained. Completed: 26/04/2024

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life: A Comprehensive resident assessment and Care plan audit was completed by a member of the senior management team on the 30/03/24. All residents have person-centered end-of-life care plans in place which are reflective of all of the residents' individual needs, wishes and preferences. Completed: 16/04/2024 A post-admission audit is completed 48 hours post the admission of a resident to Craddock House which now includes the question "is the development of person-centered end-of-life care plans within 48 hours post-admission in place"? A resulting Quality Improvement plan is completed post each of the admission audits and actioned based on each individual audits' findings. The Post admission audit findings continue to be reviewed by the Director of Nursing and the Registered Provider Representative at the weekly admissions meetings. Resident Assessment and person-centered care plan training was provided by the Group Director of Quality, Safety and Risk and has been completed by each staff Nurses and all members of the management team in Craddock House. Training completed on 15/04/2024, 09/05/2024, 29/05/2024. Completed 29/05/2024 A Quality iniatitive named "The Care plan Project "commenced on 03rd May 2024 and is ongoing presently ,expected date for completion on 30/08/2024. . The Care plan Project focuses on each domain of care to ensure that each individual resident care is planned and implemented according to their individual wishes, strengths ,abilities and needs and to ensure that assessments and care plans are completed within the required timeframe and reviewed at least 4-monthly in-line with policy and procedure or if and when a residents holistic care needs change. The project is currently being audited weekly by a member of the senior management team. Completion Date: - 30/08/2024 A Management of End-of-Life Care audit tool has been implemented and is completed no later than forty-eight hours following a resident's death. The audit tool includes end of life assessments, management of residents end of life care needs and the continuous review of person-centered care plans at end of life. Completed: 29/05/2024.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The bed identified on day of inspection was removed from the oratory immediately to an identified appropriate storage .Should this requiremnet arise again this will be approoriately stored in central location.
Completed: 28/03/2024
The area under the stairway identified on Day 2 of the inspection reverted back to a storage area in accordance with the Statement of Purpose and the floor plans.
Completed: 17/03/2024.
An audit of all storage areas within Craddock House was completed following Day 1 of the inspection.
All designated storage areas have been assigned for specific storage purposes to ensure safe and organized storage. Designated storage areas are clearly signed which has been communicated to and re iterated to all staff.The storage areas are also included on the Daily Quality Assurance Checklist completed by the management team.
Completed: - 08/04/2024.
The broken and unused equipment identified on Day 1 of the inspection within Craddock House and in the external area were immediately removed and disposed of appropriately .
Completed: - 29/03/2024.
Personal belongings of existing residents identified on Day 1 of the inspection being stored in a communal area were returned to the residents rooms and stored appropriately.
The Past residents clothing that was stored inappropriately on the day of inspection was collected by family members. A review of the management of residents personal belongings at end of life was completed. An updated standard operating procedure (SOP) is now in place to ensure personal belongings are managed and stored appropriately and respectfully.
All staff are aware of this procedure via memo which has been discussed at team meetings.
Completed – 29/03/2024.
The Management of Residents Personal Property Policy, and The End of Life and Palliative Care Policy have been updated to reflect this standard operating procedures.
The Standard Operating procedure and the updated policies have been rolled out and are readily available to all staff.
The End of Life Audit has been reviewed and now includes appropriate management of residents personal belongings at end of life in-line with the updated End of Life Policy.
Completed – 28/05/2024
A Second handrail on the stairwell is scheduled to be installed by 30/07/2024. A risk assessment is completed for the safe use of the stairs prior to the second handrail being installed and interim control measures are in place to reduce the risk including that the Residents are encouraged to use the lifts until the second handrail is installed. For any

resident who wishes to use the stairs in the interim to move between floors this will be facilitated with support from staff .
Completion Date: 30/07/2024
Remedial work was completed to a section of the 1st floor flooring on the corridor outside rooms 72 and 73, due to water damage caused by a leak.
Completed: 02/04/2024.
A Strutural engineer completed an inspection of all areas of the 1st floor flooring on 29/04/2024. It was identifiied as part of this inspection that the depressions observed appear primarily to be as result of incorrect use of materials as part of historic works completed.
An action plan has been developed to include recommended actions and work required to the 1st floor flooring.
A contracter has been apointed and is scheduled to start the recommended works on the 05/08/204. The planned uplift works to the flooring will be upgraded by the same contractor as they close out each area on the first floor. The senior management team in conjunction with the contractor will risk assess each area individually and develop a plan prior to commencement of works to mitigate any risks and any impact to residents, visitors and staff. Information on this plan will be communicated verbally and in writing to the residents, their nominated representative and all staff including the resident forum in advance of works commencing.
Date to be completed: 23/08/2024
Electricial Wires found to be stored on top of the generator on Day 1 of the inspection were immediately removed and appropriately stored in the maintenance storage area.
Completed: 29/03/2024
The missing privacy curtains identified on Day 1 of the inspection were being laundered and no replacement was in place and were replaced on the day of inspection.
A cleaning schedule for curtains is now in place; the practice of replacing curtains sent for laundering has been discussed with all staff to ensure the residents right to privacy is consistenly maintained.
Completed: 28/03/2024.
Facilites tested the outlets highlighted during the inspection and gave assurances that all outlets would be checked and if any were found to be above 43 degrees would then be reduced .This audit was completed and 4 outlets failed which need replacement TRVs.
The replacement TRVs have been ordered and will be installed by an external competent service provider .
Completion Date: 05/07/2024
Daily spot checks of all storage areas now form part of the Manamgement Daily Quality Assurance Check list.
The Monthly Health and Safety Audit has been reviewed and updated to include inspection of the external storage areas including fire risks relating to the generator.
Findings are recorded and resulting QIP is created and actioned.
Completed: 08/04/2024
Team meetings occurred on the 02/04/2024 and 03/04/2024 and again on 06/06/2024, 07/06/2024. The Agenda included the correct procedures in place for the management of residents personal belongings, designated storage areas, safe storage of equipment, and the procedures to be followed upon identifying unused and defective equipment.
Completed: 03/04/2024
A review of the Maintenance and Repairs Policy and Procedures is currently under review and will be completed on 14th June 2024 and will be rolled out and disseminated to all

staff.
Completion Date: 14/06/2024.

A painting and decorating plan is in place which commenced on the 10/06/2024. This plan includes the painting of doors, walls and ceilings. The management team will highlight areas that require painting and review on the electronic maintenance system that are identified following completion of the scheduled monthly Health and Safety audits.
Completion Date: 15/07/2024
The skirting board in the Hair Salon was replaced and the Salon has been repainted.
Completed: 30/04/2024
The threshold where the corridor flooring meets the salon has been repaired and replaced.
Completed: 30/04/2024
The flooring to the sluice room which was damaged has now been repaired.
Completed:30th May 2024
An audit was completed on the condition of all en-suites flooring. A plan is in place to repair and/or replace the damaged flooring.
Completion Date :28/06/2024
Fire Containment have ordered the hatch and plan to install it before 31/07/2024.
Maintenance, repair and painting of the walls will then be completed
Completion Date: 31/08/2024
The home invested at the end of 2023 on improvements to the energy efficiency of the building. This consisted of   the purchase of new efficient boilers, and upgrades to the hot water cylinders, upgrades to the attic insulation and upgrades to all of the lighting fitting to LED. As a result of the LED upgrade the size of some of the hallway fitting changed and the Facilities team had a plan in place to redecorate the ceilings where required over the first two quarters of 2024. This was explained on the second day of inspection. We have engaged with an external contractor who is starting the work on the 12/06/2024 and expects the works to be complete at the end of two weeks.
Completion Date: 29/06/2024.
Health and Safety/environmental walk around inspections are now taking place weekly by the management team and include the inspection of all areas internally and externally. All Findings are recorded, and a Quality improvement plan is developed and actioned. Maintenance and repair concerns are entered onto the electronic facility system .
Completed: 01/05/2024

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:

The National Transfer Document is in place and completed when a resident is temporarily transferred or discharged. It was identified following Day 1 of the inpsection that this was not being saved electronically prior to printing at the time of resident transfer which was reviewed and rectified immediately and communicated with all staff nurses. Completion and retention of the National Transfer Document is now in place.
The audit tool for the monitoring of nursing documentation, assessment and care planning was reviewed to include the completion and retention of the national transfer document when a resident is temporarily transferred or discharged from Craddock House.
Completed 01/06/2024

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
A review of appropriate storage of residents' personal items was completed following Day 1 of the inspection. The residents' laundry baskets were returned to the residents' bedrooms and the risk in relation to infection control was discussed with all staff as part of the daily safety pauses and team meetings held 02/04/2024 and 03/04/2024 and again on 06/06/2024 ,07/06/2024.
Completed: 29/03/2024
Appropriate and safe storage within the sluice room was reviewed following Day 1 of the inspection, the storage box was removed, and items are now stored appropriately on the wall mounted racks provided. This procedure has been communicated with all staff and was discussed at the Infection prevention and Control meetings and leadership meetings.
Completed: 29/03/2024
Following Day 1 of the inspection Pest Control were contacted and were on-site 08/04/2024. Treatment was completed in both sluice rooms.
Completed: 08/04/2024.
To ensure ongoing monitoring and timely identification and response, daily checks in both sluice rooms are now included as part of the Housekeeping daily checks. Further oversight is in place and included in the daily management quality assurance checklist. A Quality Improvement plan is created following daily management quality assurance checks and findings reported to the DON.
Completed: 03/04/2024
The flooring to the sluice room which was damaged has now been repaired.
Completed :30/05/2024
The kitchenettes within the 3 Households were reviewed and deep cleaned following the inspection.
Completed: -29/04/2024
A cleaning schedule review and analysis was completed of the Kitchenettes and amended thus ensuring daily sufficient environmental cleaning is maintained including weekly deep cleans by the Catering Team. The Daily and weekly Deep cleaning schedules are signed by the person completing the cleaning and verified by the senior management on duty in

each of the individual houses.
Completed: - 01/05/2024
A weekly Kitchenette cleaning audit is now in place from 30/05/2024 and completed by the catering Lead, to ensure the appropriate standard of cleaning is maintained within the kitchenettes. All Findings are escalated to the management team on a weekly basis and the associated Quality Improvement plan.
A meeting occurred with catering staff to discuss the updated Kitchenette cleaning schedules on 06/06/2024.
Completed: - 06/06/2024
All resident equipment was deep cleaned following inspection. The cleaning of equipment Standard Operating Procedure (SOP) was reviewed and disseminated to all staff. To support the ongoing monitoring, a record is being maintained of the cleaning and tagging of all individual residents' equipment and completed by team on duty. Daily spot checks of this process is included in the Daily Quality Assurance Management checklist.
Completed: 07/06/2024.
Part of the required compliance plan for this regulation is also included in Regulation 23 regarding the clinical hand wash sinks.
The installation of a clinical hand wash sink in accordance with the required specifications in Rose Cottage clinical room is scheduled for 02/08/2024
Completion Date: 02/08/2024
Staff Nurses have access to wall mounted hand sanitizer within the clinical room area and access to the clinical hand wash sink in Rose Cottage Day room.
Completed: 19/04/2024

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Part of the assurance required for this regaulation is also included in Regulation 23.
Three additional Ski pads were sourced and were in place by the evening of the day 2 of inspection on 16/04/2024. This provided assurance that sufficient fire evacuation equipment was in place to safely evacuate all residents in the event of a fire.
Completed: - 16/04/2024
On inspection it was identified the fire door to the kitchen was catching on the flooring which impacted on the door closing. This was reviewed by the Facilities manager and repairs were completed. This fire door is now closing fully and remains closed at all times.
Completed: - 30/04/2024
The electrical store room was cleared of all combustable materials during Day 2 of the inspection.
Completed: 16/04/2024
Fire Containment reviewed the fire doors. Six fire doors were identified to be replaced with the appropriate fire rating and a plan is in place to replace these fire doors.
Completion Date: 31/07/2024
Inspections have been completed regarding the Fire compartment door near room 43

and the location of the door does require to be adjusted by one meter. The door was one of the six noted above and will be replaced in the correct location.
Completion Date: 31/07/2024
The PAS 79 raised a question and review of fire certificate, this review confirmed the wall in question is not a fire rated wall on the fire cert and was closed on the PAS 79.
The door of the decommissioned lift shaft is one of the six noted above and is scheduled to be replaced.Completion date: 31/07/2024
Fire Containment will repair the plasterboard of the wall of a fire compartment boundary when on site to install the new fire doors.
Completion date: 31/07/2024
The fire alarm has been activated and the shutter closed as designed. Once the fire alarm has been reset the shutter is raised manually by staff in the bedroom. Training is being rolled out to staff on the checking and manual operation of the roller shutter. 50 of all staff have completed this training to date and further training is scheduled daily for remaining staff to complete the required training by 30/06/2024.Depending on the use of the shutter it is sugested that a 6 months inspection by a competent engineer and a full yealy inspection. A quartery inspection of the system and a full service has been added to our contractors SLA. A service has been scheduled to take place on 15/06/2024
Completion Date: 15/06/2024
Our Capital Project Manager has engaged with an external approved certified person and requested confirmation on the assurance required to complete works to the multiple penetrations through fire rated ceilings . Completion Date:30/06/2024.
The installation of the smoke detector has been scheduled for 28/06/2024
Completion Date: 28/06/2024
Our Capital Project Manager has reviewed the information on site and has been unable to determine the fire rating of the product on the ceiling. Fire Containment quote to install ES/VFR Primer and HW01 fireproof coating to the recpetion and conservitory ceilings has been approved and the planned comencment date is 16/08/2024
Completion Date: 16/08/2024
A full door audit was completed on 07/06/2024 any fails identified created work orders for the Facilities team to close out. These deficits are ongoing and will be closed out by the end of June.
Routine fire rated door inspections including smoke seals are scheduled to take place 6 monthly and will be completed by the facilities manager. Re-training in this area will be completed with the in-house maintenance staff member.
Completion Date: 30/06/2024
On the day of inspection two areas were identified where improvements in external emergancy lighting could be made and two locations that required running man signs.
The installation of the upgrades have been sheduled in June.
Completion Date: 30/06/2024
Following inspection the fire drill recording template has been reviewed and updated to ensure the accurate and complete recording of the effectiveness and learning from every fire drill.
Weekly fire drills have been completed since inspection simulating the use of evacuation mats for residents on the 1st floor down the stairs to ensure an efficient evacuation procedure is in place and staff are knowledgeable. A Quality Improvement plan has been developed and actioned based on learning from the weekly fire drill and discussed with staff at team meetings on 06/06/2024 and 07/06/2024.
Training commenced for staff on the safe evacuation of residents on the 1st floor using

the evacuation chairs. All staff nurses have completed training on the use of evacuation chairs . Training with remaining staff is scheduled and will be completed by 30/07/2024.
Date to be completed by: 30/07/24
Fire drills and routine training have been completed using the evacuation equipment and have been found to be effective for safe evacuation of residens through doorways, down stairs and along external escape routes. Photographic evidence has been mantained for learning and evidence purposes. Evacuation from the 1st floor using evacuation aids in place will continue to form part of the scheduled fire training and fire drills.
Completed: 12/06/2024
The charging points for the equipment batteries which were located on the corridor are relocated to the equipment store room.
Completed: 24/06/2024
A risk assessment was completed for the existing residents smoking shelter. As a result a new resident smoking shelter manufactured with reduced combustable materials is ordered and will be delivered on Monday 01/07/2024. The new smoking shelter will be installed within the outdoor courtyard in a location away from all residents bedrooms, and will be completed by Friday 05/07/2024. Interim control measures are in place to reduce the risk of fire including the heater in the smoking shelter is disconnected as an immediate control measure on 27/06/2024. Any residents who chooses to smoke ciggarrettes in Craddock house is risk assessed to ensure measures are in place in realtion to risks around fire. There is a nurse call bell fitted within the smoking shelter.
Completion Date:05/07/2024

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:
Part of the response to this regualtion is also included in the compliance plan for Regulation 23.
A detailed audit was completed following inspection on all resident assessments and care plans to identify any gaps in – care plan reviews being completed 4 monthly or sooner if a resident need changed, following hospital admission, a serious incident including safeguarding incidents or when approaching end of life. The audit included a review of a person-centered approach to care planning. An associated Quality Improvement plan was developed and is currently in progress.
Completed: 30/03/2024
Assessment and person-centered care plan training was provided by the Group Director of Quality and Risk and has been completed by all Staff Nurses and the management team. Training completed on 15/04/2024, 09/05/2024, 29/05/2024.
Completed: 29/05/2024
A post-admission audit is completed 48 hours after every admission, including the development of person-centered end-of-life care plans within 48 hours post-admission as discussed under Regulation 23.

This post admission audit has aslo been introduced for all residents returning to Craddock House post a hospital admission to ensure all clinical risk assessments are updated, changes to residents needs are identified and care plans are reviewed and updated to reflect changes and inform care delivery.
Completed: - 01/05/2024.
Post any safeguarding incident ,residents careplans are updated and are fully reflective of the incident .The safeguarding careplans are discussed at ecah handover thus ensuring that all staff are fully informed and knowledgable of the protective measures in place to safeguard the residnet
Completed: 16/04/2024

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	16/04/2024
Regulation 13(1)(b)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met.	Substantially Compliant	Yellow	16/04/2024
Regulation 13(1)(c)	Where a resident is approaching the end of his or her	Substantially Compliant	Yellow	16/04/2024

	life, the person in charge shall ensure that the family and friends of the resident concerned are, with the resident’s consent, informed of the resident’s condition, and permitted to be with the resident and suitable facilities are provided for such persons.			
Regulation 13(1)(d)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that where the resident indicates a preference as to his or her location (for example a preference to return home or for a private room), such preference shall be facilitated in so far as is reasonably practicable.	Substantially Compliant	Yellow	16/04/2024
Regulation 13(2)	Following the death of a resident the person in charge shall ensure that appropriate arrangements, in accordance with that resident’s wishes in so far as they are known and are reasonably practical, are made.	Substantially Compliant	Yellow	16/04/2024

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.	Not Compliant	Orange	31/08/2024
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Red	10/04/2024
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	05/06/2024
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which	Not Compliant	Orange	01/06/2024

	the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
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.	Not Compliant	Orange	02/08/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Red	10/04/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/06/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for	Not Compliant	Red	10/04/2024

	maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	26/04/2024
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	30/07/2024
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is	Substantially Compliant	Yellow	12/06/2024

	reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	16/08/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	10/04/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	30/05/2024
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	30/08/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not	Substantially Compliant	Yellow	30/08/2024

	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.			