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:	Prague House Care Company Limited By Guarantee
Name of provider:	Prague House Care Company Limited By Guarantee
Address of centre:	Chapel Street, Freshford, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	02 December 2024
Centre ID:	OSV-0005447
Fieldwork ID:	MON-0045585

About the designated centre

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

Prague House is located on Chapel Street, Freshford, Co. Kilkenny. The centre is a two-storey building that is registered to accommodate 15 people. The management of Prague House is overseen by a Board of eight Directors. The centre caters for men and women from the age of 60 years. The statement of purpose states that the centre does not provide 24-hour nursing care, and provides low-medium dependency care 24 hours a day. The statement of purpose states that care is delivered in a homely, comfortable and hygienic environment. The centre manager is employed to work on a full-time basis. Residents do not require 24-hour nursing care, and care is provided by a team of trained healthcare professionals. According to the centre's statement of purpose, all applicants for admission must be mobile, and mentally competent at the time of admission. Each resident is provided with single bedroom accommodation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Monday 2 December 2024	10:00hrs to 18:00hrs	Mary Veale	Lead
Monday 2 December 2024	10:00hrs to 18:00hrs	Niall Whelton	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day by two inspectors. Based on the observation of the inspectors, and discussions with residents and staff, Prague House was a nice place to live. There was a welcoming and homely atmosphere in the centre. The inspectors spoke with three residents living in the centre. Residents spoken with were very complimentary in their feedback and expressed satisfaction with the food served, activities programme and staff. Interactions observed were seen to be respectful towards residents and all residents spoken with knew the person in charge and confirmed their accessibility to her.

Prague House is located in the village of Freshford, Co. Kilkenny. Residents had access to the local shops, church, post office, coffee shop, GP's surgery and local community groups.

The design and layout of the premises met the individual and communal needs of the residents'. The building was well lit, warm and adequately ventilated throughout. Residents had access to an open plan dining and sitting room, a separate sitting room, meeting room, conservatory and an oratory. The centre was registered to accommodate 15 residents. The centre was homely and clean, and the atmosphere was calm and relaxed. The building comprised of two levels with the ground floor accessible to residents. The first floor of the building was not part of the service.

Residents were accommodated in 15 single rooms. The centre had two corridors- Achadh Úr and Cascade. 10 bedrooms were on the Achadh Úr corridor and five on the Cascade corridor. Two single rooms had en-suite shower, toilet and wash hand basins. All of the remaining single rooms had wash hand basins. Residents' bedrooms were clean and tidy. Bedrooms were personalised and decorated in accordance with resident's wishes. Lockable storage space was available for all residents and personal storage space comprised of a locker, drawers and double wardrobes. All bedrooms were bright and enjoyed natural light. Residents had access to two shared shower rooms, and five toilets.

Residents had access to an enclosed courtyard yard and a garden to the rear of the building. There were hens living in a secure area in the back garden which were cared for by a resident. The centres designated smoking area was located outside; opposite the centres conservatory room.

The centre provided a laundry service for residents. All residents' whom the inspectors spoke with on the day of inspection were happy with the laundry service and there were no reports of items of clothing missing.

Residents were very complimentary of the home cooked food and the dining experience in the centre. Residents' stated that the quality of food was excellent. The menus for all meals and snacks were conveniently displayed in the dining room.

Jugs of water and cordial were available for residents in communal areas and bedrooms. The inspectors observed the dining experience at dinner time. The dinner time meal was appetising and well present and the residents were not rushed. The dinner time experience was a social occasion where residents were seen to engage in conversations and enjoying each others company.

Residents' spoken with said they were very happy with the activities programme and told the inspectors that the activities suited their social needs. The weekly activities programme was displayed in the open planned dining/sitting room. The inspectors observed staff and residents having good humoured banter throughout the day and observed staff chatting with residents about their personal interests and family members. On the day of inspection the inspectors observed that the majority of residents left the centre after dinner time to visit the local village or visit family and friends. Residents told the inspectors they enjoyed attending the recent turning on of the Christmas lights in the village. The inspectors observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books, games and magazines were available to residents.

Residents' views and opinions were sought through resident meetings and satisfaction surveys and they felt they could approach any member of staff if they had any issue or problem to be solved. Residents stated that the person in charge and all of the staff were very good at communicating changes, particularly relating to their medical and social care needs.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

The inspectors found that this was a well-managed centre where the residents were supported and facilitated to have a good quality of life. The provider had progressed the compliance plan following the previous inspection in February 2024. Improvements were found in care planning, premises, records, governance and management, contracts of care, infection control, fire safety, reporting of incidents and complaints procedure. On this inspection, the inspectors found that actions was required by the registered provider to comply with areas of Regulation 17: Premises and Regulation 28: Fire precautions. The inspectors followed up all statutory notifications received by the Chief Inspector of Social Services since the previous inspection.

Prague House Care Company Limited by Guarantee comprised of nine directors is the registered provider for Prague House. The centre provides care for low to medium dependent residents who do not require full time nursing care in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 as amended. The person in charge

reported to the board, worked full time in the centre and was supported by an assistant manager and a team of nursing, care and support staff.

There were sufficient staff on duty to meet the needs of residents living in the centre on the day of inspection. The centre had a well-established staff team who were supported to perform their respective roles and were knowledgeable of the needs of older persons in their care and respectful of their wishes and preferences.

There was an ongoing schedule of training in the centre and management had good oversight of mandatory training needs. An extensive suite of mandatory training was available to all staff in the centre and training was up to date. There was a high level of staff attendance at training in areas such as fire safety, manual handling, safeguarding vulnerable adults, and infection prevention and control. Staff with whom the inspectors spoke with, were knowledgeable regarding infection control procedures and fire procedures.

There were good management systems in place to monitor the centre's quality and safety. There was evidence of a comprehensive and ongoing schedule of audits in the centre, for example; infection prevention and control, falls, care planning and medication management audits. Audits were objective and identified improvements. Records of board meetings and staff meetings which had taken place since the previous inspection were viewed on this inspection. Board meetings took place six weekly and staff meetings took place quarterly in the centre. Agenda items on meeting minutes included key performance indicators (KPI's), fire safety, training, resident feedback, activities, links with the community and infection prevention. The person in charge submitted and discussed a report with the board which included items such as staffing, training, safe guarding, and resident feedback. It was evident that the centre was continually striving to identify improvements and learning was identified on feedback from resident's meetings and audits. The annual review for 2023 was available during the inspection. It set out the improvements completed in 2023 and improvement plans for 2024.

All manual records and documentation were well-presented, organised and supported effective care and management systems in the centre. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 were available in the designated centre for each member of staff. Garda vetting disclosures viewed by the inspectors were received prior to the staff commencement date of employment.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes. The inspectors followed up on incidents that were notified since the previous inspection and found these were managed in accordance with the centre's policies.

Improvements were found in complaints management. The centre's complaints policy and procedure had been updated to reflect the regulations (S.I 628 of 2022), which came into effect on 1 March 2023. The complaint and review officer had completed training to deal with complaints. The management team had a good

understanding of their responsibility in respect of managing complaints. The inspectors reviewed the records of complaints raised by residents and relatives and found they were appropriately managed. Residents spoken with were aware of how to make a complaint and whom to make a complaint to.

Regulation 15: Staffing

On the inspection day, staffing was found to be sufficient to meet the residents' needs. There was a minimum of one healthcare assistant on duty in the centre at all times for the number of residents living in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safe guarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up to date training to enable them to perform their respective roles. Staff were appropriately supervised and supported.

Judgment: Compliant

Regulation 21: Records

All records as set out in schedules 2, 3 & 4 were available to the inspectors. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

Management systems were effectively monitoring quality and safety in the centre. Clinical audits were routinely completed and scheduled, for example; falls, medications, and complaints. These audits informed ongoing quality and safety improvements in the centre. There was a proactive management approach in the

centre which was evident by the ongoing action plans in place to improve safety and quality of care.

Judgment: Compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. These clearly outlined the room the resident occupied and additional charges, if any.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider provided an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the investigation into, and review of complaints was specified in the procedure. The procedure was prominently displayed in the centre. The complaints procedure also provided details of the nominated complaints and review officer. These nominated persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Overall, the inspectors were assured that residents living in this centre enjoyed a good quality of life. Staff were seen to be respectful and courteous towards residents. There were good positive interactions between staff and residents observed during the inspection. On this inspection further improvements were required to comply with an areas of the premise and fire safety.

Improvements were found in individual assessment and care planning since the previous inspection. The inspectors viewed a sample of residents' paper based notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Care plans viewed by inspectors were generally person- centred, routinely reviewed and updated in line with the regulations and in consultation with the resident. There was a daily record

of the residents overall health recorded by a healthcare assistant and a weekly nursing record of the resident's health and treatment where appropriate.

Improvements were found in infection control, staff had completed training in cleaning procedures. The centre was clean, with good routines and schedules for cleaning and decontamination. Alcohol hand gel was available in all communal rooms and corridors. Personal protective equipment (PPE) stations were available on all corridors to store PPE. Used laundry was segregated in line with best practice guidelines and the centres laundry had a work way flow for dirty to clean laundry which prevented a risk of cross contamination. There was evidence that infection prevention control (IPC) was an agenda item on the minutes of the centres management and staff meetings. IPC audits were carried out by the person in charge. There was an up to date IPC policies which included guidance on COVID-19 and multi-drug resistant organism (MDRO) infections. Housekeeping staff were knowledgeable of correct cleaning and infection control procedures. Intensive cleaning schedules had been incorporated into the regular cleaning programme in the centre. The person in charge had completed infection prevention control (IPC) link nurse training.

Improvements had been made to the premises since the previous inspection, a new sluice room and housekeeping room had been installed. A schedule of maintenance works was ongoing, ensuring the centre was consistently maintained to a high standard. Bedrooms were personalised and residents had ample space for their belongings. Overall the premises supported the privacy and comfort of residents. Grab rails were available in all corridor areas, bathroom, shower rooms and toilets. Residents has access to a call bells in their bedrooms, en-suite rooms, bathroom, shower rooms and toilets. Improvements were required to the premises which is discussed further in this report under Regulation 17.

There was good oversight of fire safety management in the centre. In house fire safety checks of means of escape and fire equipment were completed by staff. Fire safety systems, such as the fire alarm, fire fighting equipment and the emergency lighting were being serviced and completed within the required time frames. The annual service record for the emergency lighting system however did not reflect the appropriate test; the provider confirmed this would be actioned. The provider was awaiting new fire safety evacuation maps to be completed.

Escape routes were clear and residents assessed needs were clearly documented, including an alternative safe location if the building required full evacuation. Improvements were required in relation to fire precautions which is discussed further in this report under Regulation 28.

There was a rights based approach to care in this centre. Residents' rights, and choices were respected. Resident feedback was sought in areas such as activities, meals and mealtimes and care provision. Records showed that items raised at resident meetings were addressed by the management team. Information regarding advocacy services was displayed in the centre and records demonstrated that this service was made available to residents if needed. Residents has access to daily

national newspapers, weekly local newspapers, Internet services, books, televisions, and radio's.

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in schedule 6 of the regulations, for example;

- Bedroom walls where overhead lighting had been installed required review as there was gaps in the plaster board.
- A review of the centres blind cords was required as some did not have a safety device which posed a health and safety risk.
- A review of shelves in store rooms and presses was required as staff could not effectively clean the shelves. This posed a risk of cross-contamination.
- There was a leak in the roof of the main building which required repair
- the ceiling in the lift motor room was damaged from an ingress of water and required repair
- Temperature in plant room was very warm and was not adequately ventilated. Any solutions to provide appropriate ventilation will require input from a competent professional
- The garden to the rear of the centre had items awaiting disposal.

Judgment: Substantially compliant

Regulation 27: Infection control

The centre was very clean. Staff were observed to be adhering to good hand hygiene techniques. There was a sluice room and cleaners room in the centre which were clean and well maintained. The registered provider was implementing procedures in line with best practice for infection control. Effective housekeeping procedures were in place to provide a safe environment for residents and staff.

Judgment: Compliant

Regulation 28: Fire precautions

Notwithstanding the good fire safety management systems in place and the progress made on the programme of fire safety works, further improvements are required to ensure adequate precautions against the risk of fire:

- there was paraffin candles in the oratory, which were not risk assessed. The inspectors were informed these would be removed
- a storage press had items stored against an electrical socket within the press. Risk assessment is required to determine safe storage practices in this enclosure
- there was a survey of electrical boards in the building. It was not clear as to the outcome of the survey and if remediation work was required; assurance was required in this regard.

While fire containment in the designated centre was generally to a good standard, further assurance was required where mechanical extract units and recessed light fittings penetrated the fire rated ceiling to ensure adequate containment of fire. There were minor holes and gaps where wires passed through fire rated walls or ceilings which required sealing up. The enclosure to a plant room also had a hole in the wall and required sealing up.

The oratory was fitted with a heat detector and not a smoke detector to ensure adequate detection and early warning of a fire. The schedule of zones displayed beside the fire alarm panel did not accurately reflect the configuration of the building and required updating.

While the emergency lighting system was being serviced at the appropriate intervals, the service records did not show that an annual test was completed in line with the standards for emergency lighting.

The periodic inspection report for the fixed wire electrical installation, completed in October 2024, included some remedial actions and there was no record of these remedial works being completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs. Care plan reviews were comprehensively completed on a four monthly basis to ensure care was appropriate to the resident's changing needs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The person in charge ensured that staff had up-to-date knowledge, training and skills to care for residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort,

or discomfort with their social or physical environment). There were no residents living in the centre who behaved in a manner which was challenging. There were no restrictive devices in use in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. There was a focus on social interaction led by staff and residents had daily opportunities to participate in group or individual activities. Access to daily newspapers, television and radio was available. Details of advocacy groups was on display in the centre.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Prague House Care Company Limited By Guarantee OSV-0005447

Inspection ID: MON-0045585

Date of inspection: 02/12/2024

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Overhead Lighting and Gaps in Plasterboard: • Works have taken place to review and repair the affected walls. All gaps in the plasterboard have been filled, sanded and sealed to ensure compliance with fire safety and aesthetic standards. This work was completed 17.12.24 Blind Cords and Safety Devices: • We have held a full review of all blind cords in the centre. Full replacement and or the addition of safety devices will be installed on any blinds without such mechanisms to eliminate potential risks, we have opted for spring loaded, fire retardant, washable blinds. This work will be completed by 18.02.25. Shelves in Storerooms and Presses: • A washable paint has been purchased to ensure all shelving can be easily cleaned and disinfected, reducing the risk of cross contamination. The maintenance team are currently actioning this item, and all surfaces will be finished to a satisfactory standard by the 11.03.25. In the meantime, staff have been reminded to ensure interim cleaning efforts are thorough. Leak in the Roof: • The roof leak has been assessed, and repair works have commenced with a contractor, the timeline for completion is 23.04.25 Ceiling in the Lift Motor Room: • The water-damaged ceiling in the lift motor room will be repaired as part of the roof repairs. Further water ingress prevention measures will be carried out to avoid future repeats. The timeline for completion is also 23.04.25 Plant Room Ventilation: • We have engaged a qualified professional to assess the ventilation system in the plant room and have commenced works based on their recommendations to address the high temperature. These works will be completed by 28.04.25 Garden Disposal Items: • The garden items awaiting disposal will be removed. Arrangements have been made with a waste management service to ensure this area is cleared within a 1-month period. 28.02.25.	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Removal of Paraffin Candles in the Oratory
• All paraffin candles in the oratory have been removed.
Storage Press Risk Assessment
A comprehensive risk assessment has taken place and control measures have been put in place to ensure fire safety and safe storage practices are adhered to. These include:

• Items should never be stored directly against or on top of electrical sockets.
• A clearly marked safety zone is outlined with instruction around electrical sockets (minimum of 30cm).
• A fire rated metal enclosure shall be provided for the electrical controls in the storage press to ensure no direct contact is made.
• Staff education on proper storage practices and electrical safety precautions is being implemented.
• Regular audits and checks to ensure compliance with these new controls.
Electrical Board Survey and Assurance of Remedial Work
The Electrical Board Survey has been reviewed by a qualified electrician, who confirmed that it was an internal report carried out on the entire premises for the Board of Directors and that there were no deviations from ETCI safety standards. Furthermore, the distribution boards were assessed as part of the periodic service review last year and has confirmed that all are in a satisfactory condition and that no remedial work was considered necessary.
Fire Containment Measures
We have engaged a qualified professional to assess the facility and develop a methodology to address any defects identified including issues raised in our most recent inspection.
This will ensure that the mechanical extract unit is designed and installed correctly to remove hot air from the repurposed old Boiler Room to atmosphere, the hot water storage and pipe manifolds are insulated adequately and that all recessed light fittings meet fire containment standards. They shall also ensure that the ceiling and walls in the Old Boiler Room are upgraded to provide a 60-minute fire retention rating. Works are ongoing presently and we expect to have this completed by 28.02.25
Installation of a Smoke Detector in the Oratory
• Action: Replace the current heat detector with a smoke detector to ensure early fire detection works to be completed by 01.03.25
Updating Fire Alarm Panel Zone Schedule
A full review of the fire zones schedule and required amendments has taken place on 04.02.25. This more accurately reflects the configuration of the building. Following the installation of the addressable fire alarm panels further review will take place to ensure optimal zoning and compliance with fire safety regulations. Any amendments will be included in the schedule of zones displayed.

Emergency Lighting System – Completion of Annual Testing
The required three-hour emergency lighting test was successfully completed on 14.12.24 in accordance with I.S. 3217:2023 standards.
Completion of Remedial Works from Fixed Wire Electrical Installation Report (October 2024)

A revisit from the electrical contractor and a further review of the period service report took place. An amendment was added to the report stating that "Installation checked throughout, all in satisfactory condition". This took place on the 24.01.25

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/04/2025
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.	Substantially Compliant	Yellow	01/03/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape,	Substantially Compliant	Yellow	01/03/2025

	building fabric and building services.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/03/2025