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:	St Camillus Nursing Centre
Name of provider:	Order of St Camillus
Address of centre:	Killucan, Westmeath
Type of inspection:	Unannounced
Date of inspection:	25 March 2024
Centre ID:	OSV-0000098
Fieldwork ID:	MON-0043075

About the designated centre

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

St. Camillus Nursing Centre was established in 1976 and is registered for a maximum capacity of 57 residents, providing continuing, convalescent, dementia, respite and palliative care to male and female residents primarily over 65 years with low to high dependency needs. The centre is located on the outskirts of Killucan in Co. Westmeath close to where four counties meet. All accommodation and facilities are at ground floor level and are well maintained. A variety of communal facilities for residents use are available. A number of sitting rooms, a quiet room, visitor's room and seated areas are available. Two dining rooms are located at the front of the building, with one adjoining the main kitchen. The layout and design of both dining rooms provided good outlook and views to well maintained gardens and the main driveway. A smoking room, hairdressing room and laundry facility are included in the facilities within the centre. Residents' bedroom accommodation consists of a mixture of 42 single and eight twin rooms. An end of life single room for those sharing a bedroom is included in the layout and two single bedrooms are dedicated to residents with palliative care needs. Some bedrooms have en-suite facilities while others share communal bathrooms. The centre is connected by a corridor to a splendid chapel where mass is celebrated daily and where the wider community come to meet residents. The service aims to create a caring, safe and supportive environment where residents feel secure, have meaningful activity and are encouraged to live life to the full while having their needs met. Family involvement is supported and encouraged. Staff will have appropriate training and the necessary skills to ensure care is tailored to each individual during their stay and up to the end of life.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	56

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 25 March 2024	08:00hrs to 17:00hrs	Yvonne O'Loughlin	Lead
Tuesday 2 April 2024	09:30hrs to 17:50hrs	Gordon Ellis	Support
Tuesday 2 April 2024	09:30hrs to 17:50hrs	Brid McGoldrick	Support
Monday 25 March 2024	08:00hrs to 17:00hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

This inspection was carried out over two days with day one focusing on Regulation 27: Infection Prevention and Control, due to the findings on day one, a second day of inspection was carried out.

The inspectors were greeted by the person in charge and following an introductory meeting inspectors were guided on a tour of the premises. The living areas of the centre were generally clean on the day of inspection but significant attention to cleanliness was required in the kitchen and kitchen storage areas.

The overwhelming feedback from residents was that they were very happy living in the centre. Residents and visitors who were spoken with were highly complimentary of the staff and the care they received. One resident told the inspector the centre was a 'gift ' and the staff were "very helpful". Another resident told inspectors that the management team listen to their needs. Staff were aware of the residents' needs and were striving to provide good quality care. Inspectors observed kind and respectful interactions with residents and their visitors throughout the day by staff and management. All residents observed on both days were well dressed and in appropriate clothing and footwear. Those residents who could not communicate their needs appeared comfortable and content. Staff were observed to be kind and compassionate when providing care and support in a respectful and unhurried manner.

There was a weekly plan of activities, on the day of the inspection those residents that wished to attend mass went to the chapel and in the afternoon there was music in the large sitting area that was enjoyed by a large number of residents. The Easter schedule for prayer and reflection for the week was clearly displayed in the large reception area for residents and their families to attend. One family member said "the beautiful" chapel attached to the centre allowed her to go to mass with her mother on Easter Sunday.

Inspectors found that there were no open complaints. Inspectors observed that residents approaching the end of their lives had care and comfort based on their needs, and that met their physical, emotional, social and spiritual needs. Residents' family and friends were informed of their loved one's condition and were supported to be with the resident. They were also provided with food and a sitting area.

Hand sanitisers were suitably located at the point of care throughout the centre. Some of the rooms had designated hand hygiene sinks, the residents with higher needs were accommodated in these bedrooms, where possible.

While the centre provided a homely environment for residents, significant improvements were required to protect residents who were living there from risk of infection and fire. For example, there were areas of the centre that needed maintenance and improvements in the management of infection prevention and

control and fire safety was required. These findings are discussed in detail later in the report.

The next two sections of the report will present the findings in relation to governance and management in the centre and how this impacts on the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed under the relevant regulations.

Capacity and capability

Overall, inspectors found that more robust management and oversight systems were required to ensure that the service provided to the residents was safe, appropriate, consistent, and effectively monitored.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 as amended. The Order of St Camillus is the registered provider for St Camillus Nursing Centre. The centre had recently recovered from a norovirus outbreak that affected 21 residents and two staff members.

The person in charge was supported in their role by an assistant director of nursing and two clinical nurse managers (CNMs). Due to staff shortages the CNMs were working as staff nurses which impacted on staff supervision and oversight of the centre. Furthermore, the maintenance services were working 14 hours per week this was reflected in the large amount of maintenance repairs needed on the day of inspection. This is discussed further in Regulation 23: Governance and Management, Regulation 17: Premises and Regulation 15: Staffing.

The person in charge and the assistant director of nursing had overall responsibility for infection prevention and control and antimicrobial stewardship, neither of whom had completed the national infection prevention and control (IPC) link practitioner course.

Improvements continued to be required to comply with several regulations, as discussed throughout the report. In particular, repeated non-compliance was found under the following regulations;

- Regulation 17: Premises
- Regulation 23: Governance and Management
- Regulation 27: Infection Control
- Regulation 28: Fire precautions

A number of immediate actions were required to complete the following;

- Cleaning and removal of items from a cleaning cupboard store
- Deep cleaning of the dry food store

- Removal of electrical equipment from the smoking room and the hairdressing room
- Removal of items from the hallway cupboard where the fuse board was kept

Following day one of the inspection, an urgent action plan was issued to the registered provider regarding significant identified risks and associated non-compliances with Regulation 27: Infection Prevention and Control and Regulation 28: Fire Precautions.

The provider reverted with a plan to respond to the risks identified on the day of the inspection and committed to a series of actions to ensure that these risks were controlled and mitigated going forward. The plan that was submitted was reviewed on day two of the inspection. While some actions had been progressed, a further urgent action plan was issued following day two of the inspection in respect of Regulation 27: Infection Control and Regulation and 28: Fire Precautions. A number of immediate actions to protect residents were requested on day two as follows;

- Removal of a can of oil from the boiler room
- Removal of electrical equipment from the smoking room
- Keeping the fire door free from chairs that were causing an obstruction
- Removal of a lawnmower and cans of fuel from the basement area
- Ensuring the church fire doors closed when the fire alarm was sounded

Staff roles and responsibilities were not clear in some areas. For example, there was lack of clarity as to who provided supervision for staff working in the pantry area that was situated before the main kitchen.

The centre had IPC guidelines which covered aspects of standard and transmission based precautions but the policy needed updating to reflect the new national guidance. A review of training records indicated that the majority of staff were up to date with mandatory IPC training. However, inspectors also identified, through conversing with staff, that further training was required to ensure all staff were knowledgeable and competent in the management of standard precautions, this is discussed further under Regulation 27: Infection prevention and control.

Regulation 15: Staffing

Inspectors were not assured that the provider had the required numbers of staff available with appropriate skills having regard to the size and layout of the centre and the assessed needs of residents.This was evidenced by:

- The hours allocated to maintenance was 14 hours which was not sufficient given the size, layout and grounds of the designated centre.
- There was insufficient hours allocated to the kitchen, a review of rosters confirmed that the staffing varied from three to four staff daily with one

member finishing at 2pm. The impacts of this are detailed under Regulation 27: Infection control.
- The two CNMs were working as staff nurses and this meant that staff could not receive the support and supervision that was necessary for the amount of residents in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff did not have access to appropriate training for example, in the cleaning and decontamination processes. The provider undertook to secure an external trainer and to commence training for household and kitchen staff.

Judgment: Substantially compliant

Regulation 21: Records

All documents required under Schedule 3 were not available. For example, there was no record of restraints used or the duration of the use seen for residents who had lap belts fastened while in their wheelchairs.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not sufficiently robust, as evidenced by the following findings:

- Urgent actions were required to ensure that residents were protected from the risk of fire and that fire precautions were being adequately reviewed. For example, the provider had not identified significant risks posed by; storage practices, fire doors and containment deficiencies, means of escape or the evacuation of residents in the centre, all of which had been identified by the inspectors on the day. Furthermore, immediate actions and urgent actions in regard to fire risks found by inspectors were required by the provider on both days of the inspection as outlined under Regulation 28: Fire precautions.

- Urgent improvements were required by the provider to ensure that residents were protected from the risk of infection. The findings are discussed further under Regulation 27: Infection control.
- The oversight of building maintenance required improvement as referenced under Regulation 17: Premises.
- There were insufficient assurance mechanisms in place to ensure compliance with the *National Standards for infection prevention and control in community services (2018)*. For example, local infection prevention and control audits had not been undertaken since October 2023.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the centre's registered provider. However, a revised contract was required following the provider's introduction of a social care charge to residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Some improvements were required to the Statement of Purpose to ensure that it complied with Schedule 1 of the regulations. For example, it did not contain:

- Changes to the governance structure for example, the assistant director of nursing hours had reduced.
- The purpose of rooms in the centre had changed, for example, the nurses' office was now called the salaries office
- A staff dining room had been repurposed as a kitchen store and office area and a full basement level was not described in the statement of purpose or referenced on the floor plans for the designated centre.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Some of the polices required updating. For example, the fire policy required review and updating to include procedures for the management of and the staffing requirements when the church is open to the public.

Judgment: Substantially compliant

Quality and safety

Overall, residents expressed satisfaction with the care provided and with the responsiveness and kindness of staff. However, deficits in the governance and management in the centre were impacting on the overall quality and safety of the service provided to residents.

Inspectors found that the provider did not comply with Regulation 27 and the *National Standards for infection prevention and control in community services* (2018). Weaknesses were identified in infection prevention and control governance, environment, equipment management and standard precautions. Details of issues identified are set out under Regulations 23: Governance and Management and Regulation 27: Infection Prevention and Control.

The antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress and be effective. For example, there was an over reliance on the use of dipstick urinalysis for assessing evidence of urinary tract infection, and staff had no knowledge of "Skip the Dip" which is a national initiative to reduce antibiotic consumption. This is discussed further under Regulation 27: Infection prevention and control.

Some barriers to effective hand hygiene practices were observed during the course of this inspection. Clinical hand washing sinks were not available within easy walking distance from all residents` rooms, some residents' bedrooms did have designated hand hygiene sinks, staff said these rooms were allocated for residents with higher needs. Alcohol-based hand-rub was available in wall mounted dispensers that were clean and in good working order. This is discussed further under Regulation 27: Infection Prevent and Control.

Paper based care plans were available for all residents with a folder compiled for each resident that was organised and easily accessible. Residents who had a urinary catheter had a care plan to guide care. The national transfer document was not in use for when residents are transferred to an acute hospital, however the centres own document had a section which captured the residents' infectious status.

The provider had substituted traditional needles with safety engineered sharps devices to minimise the risk of a needle stick injury. Waste and sharps were managed in line with best practice guidance. Improvements were required in the

management of linen and this is discussed further under Regulation 27: Infection Prevention and Control.

There were no visiting restrictions in place and visits and social outings were facilitated and encouraged. Friends and relatives were seen coming and going on the days of the inspection and this contributed to the relaxed and friendly atmosphere for residents in the centre.

The oversight of fire safety and the processes to identify, and manage fire safety risks did not effectively ensure the safety of residents living in the centre. On the first day of the inspection, the provider was issued with immediate actions and an urgent compliance plan to address areas of risk to residents' safety.

These risks were in regards to; inappropriate storage practices in relation to flammable items in a number of areas, personal emergency evacuation plans (PEEPS) had not been updated to reflect the equipment and resources required to evacuate residents day and night, records of fire drills for the largest compartment were not available and assurances were required as to the location of the compartment boundaries.

Following day two of the inspection, it was noted that the majority of risks identified on day one of the inspection had not been addressed by the provider. However, on day two of the inspection, the inspectors identified repeated and additional fire risks that warranted a second immediate action and an urgent compliance plan. The inspectors' findings are outlined in detail under Regulation 28: Fire Precautions.

There were inappropriate fire containment arrangements. For example, inspectors identified that doors along the corridors had gaps over the permissible tolerance. Door closing mechanisms were missing on the kitchen hatches and some doors did not appear to meet the criteria of a fire door. The provider submitted a fire door audit which identified a significant number of doors that required fire safety works to ensure they were effective.

In addition to this, fire rated ceilings had gaps and holes that required fire sealing to maintain the fire rating and a number of ceiling attic hatches did not appear to be fire rated.

The records provided on the days of inspection showed that the fire detection and the alarm systems, gas system, fire extinguishers were maintained and serviced. However, the annual and quarterly service and maintenance records were not available for the emergency lighting system.

Other concerns were identified in regards to the management of keys to access fire exits, evacuation floor plans and the evacuation of residents. These and other fire safety concerns are detailed further under Regulation 28: Fire Precautions.

Regulation 17: Premises

There was inappropriate storage seen across the residential centre. For example:

- The basement was full of boxes of personal protective equipment (P.P.E), furniture, lawn-mower, paint inappropriately stored in the basement area. This storage also impacted on fire safety which is further discussed under Regulation 28; Fire Precautions.
- The area near the stairs had a large amount of inappropriate storage such as crutches, commodes and large chairs. In addition to being stored inappropriately the fire door exit was blocked.
- Storage of electrical equipment in the smoking room

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance and repair to be fully compliant with Schedule 6 requirements. For example:

- Some parts of the centre required an upgrade of the emergency call bell system. Inspectors acknowledged that the provider had identified this necessary action themselves. While a call bell is provided in the dining room, it is not accessible to residents and its location required review.
- Externally a path on the exit route had moss on it which posed a safety risk when exiting the centre.
- A electric socket was coming off the wall in a room beside the church
- Ceiling tiles in a number of rooms were stained and required replacement including the suspended ceiling near room 12 and also the ceiling at the nurses station.
- The ceiling in the visitors toilet had evidence of water damage
- Some of the doors had signs of damage and a number of ceiling areas had holes that required sealing up.

The registered provider did not ensure that the premises of the designated centre was in accordance with the statement of purpose prepared under Regulation 3; for example:

- To access the staff dining room, staff were required to travel through the kitchen
- There was not enough suitable communal space for residents` social activities. The area identified on the floor plans as communal space was being used for staff, this meant reduced available communal space for residents. Inspectors observed up to 20 residents in one sitting area.
- There was not enough shower facilities, having regard to the dependencies of persons, there was one shower short.
- There was not a sufficient supply of piped hot and cold water available on both days of the inspection, a number of taps in the kitchen ,sluice and toilets did not have hot water. Documentation viewed showed that the water supply was from the rising mains, however there was uncertainty regarding the internal distribution of potable water.

- There was not suitable storage provided to store both resident and staff records.
- A number of toilets and at least one shower had only one grab rail, a full review of the premises is required in this regard.
- A number of ceiling fans were not in good condition, and they also required maintenance and cleaning.

Judgment: Not compliant

Regulation 27: Infection control

Infection prevention and control and antimicrobial stewardship governance arrangements did not ensure the sustainable delivery of safe and effective infection prevention and control. For example:

- There was no evidence of antimicrobial stewardship quality improvement initiatives or up-to-date IPC guidelines to guide staff in their day-to-day practices.
- The IPC link practitioner had not attended the national IPC link practitioner programme this meant that the IPC Link practitioner may not have received national updates and were kept up-to-date from peer support.
- Policies available to guide staff needed updating to reflect the new *National Clinical Guideline No.30 (IPC*) May 2023.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by:

- Some of the en suite rooms in the older wing had a chipboard surface behind the toilet which was torn in parts and this meant it was difficult to clean.
- On the first day of the inspection, the small kitchen preparation area and the main kitchen was visibly dirty. On the day two of the inspection, the inspectors observed a bain-marie in use that was not clean.
- The sluice room did not support effective infection prevention and control. For example, the bedpan washers in two of the sluices did not have the appropriate cleaning solution available in line with the manufacturer's instructions. This meant that bedpans and urinals may not have been effectively cleaned.
- There was no designated cleaning store room for kitchen cleaning equipment. Cleaning equipment for the kitchen was stored outside the kitchen and the mop buckets were visibly dirty. Equipment that is not clean increases the risk of infection cross contamination and spread of infection.
- There was no staff toilet dedicated for kitchen staff to prevent cross contamination from the kitchen to resident areas.

- Clinical hand hygiene sinks were not available within easy walking distance from all residents rooms for staff to clean their hands if visibly soiled, this increases the risk of transmitting a healthcare associated infection.

Standard infection prevention and control precautions were not effectively and consistently implemented by staff. This was evidenced by;

- The inspectors observed one member of staff transporting dirty linen in their arms whilst wearing a long sleeved cardigan.This poses a risk of infection spread.
- One staff member was making beds and stored the dirty linen on top of the clean linen thus causing the clean linen to be contaminated and further increase the risk of infection spread.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider was non-compliant with the regulations in the following areas:

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

On the first day of the inspection the provider was issued with immediate actions and an urgent compliance plan due to inadequate fire precautions. For example:

- Inappropriate storage practices were found in relation to flammable items next to electrical panels in a number of areas that included a room beside a church and under a staircase. This created a fire risk and the storage of large amounts of flammable items in one area created a fire hazard should a fire occur. The provider had arranged for these to be removed.

On the second day of the inspection the provider was again issued with immediate actions and an urgent compliance plan due to inadequate fire precautions. For example:

- Inappropriate storage practices in relation to machinery, flammable and combustible items were found in the basement and in an external boiler room.
- In addition to this, a number of bins were found to be stored up against the external wall of the centre, an oxygen cylinder was stored outside and was not secured, a deep fat fryer was in use in the kitchen however a fire

suppression system was not in place and the inspectors identified gaps in the records for checking the evacuation ski-sheets.

The provider did not provide adequate means of escape including emergency lighting. For example:

A fire exit from a church was found to be locked with a key and a steel bar. The key was not located adjacent to this fire exit. An immediate action was issued to the person in charge to remove the steel bar and fit a key beside the door. In addition to this, the inspectors were not assured the timber ceiling in this area would meet the required fire rating criteria as it was on a means of escape.

At the rear of the centre the inspectors identified an external evacuation route was not suitable to evacuate residents to the front fire assembly point. This was evidenced by; the lack of emergency lighting to illuminate the path in the event of a night time evacuation, the steep gradient, the condition of the path, the inappropriate fire assembly point signage and its location beside a river.

A lack of emergency lighting was identified above some of the external fire exits. There were areas internally where the directional emergency signage was not illuminated and in a basement there was no emergency lighting fitted.

The registered provider did not make adequate arrangements for maintaining the means of escape, building fabric and building services. For example:

In the kitchen, a number of fire exits were locked. The arrangements for the management and access to keys was not adequate as keys were not placed next to all fire exits and staff did not carry a master key on their person for fire exits. In a store room, the inspectors identified this area as being cluttered with chairs and wheelchairs that blocked access to a fire exit out of this room. Furthermore, it would be difficult for staff to remove these wheelchairs in an evacuation of residents.

Along a corridor the inspectors identified a wall of wooden cabinets that housed a large electrical unit and flammable items. The electrical unit was not encased in fire rated construction. This created a fire risk.

The provider was working through a programme of fire sealing. Notwithstanding this, some areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings and required appropriate fire sealing measures. This was a repeated finding from an inspection in September 2023.

Up-to-date annual or quarterly service and maintenance records were not available on the day of the inspection to ensure the emergency lighting system was being regularly serviced by a competent technician.

The registered provider did not make adequate arrangements for reviewing fire precautions:

Due to the lack of fire oversight, the number of immediate actions, urgent action plans and the level of identified fire risks observed over the course of the two day inspection, the provider was required to arrange for a competent fire person to carry out a full fire safety risk assessment of the entire centre.

The registered provider did not ensure by means of fire safety management and fire drills at suitable intervals, that the persons working in the designated centre and, in so far is reasonably practical, residents are aware of the procedures to be followed in the case of fire.

A fire evacuation drill had not been completed since January 2023. This is a repeated finding from the September 2023 inspection. Furthermore there was no drill recorded to evidence the safe evacuation from the largest compartment which at the time could accommodate 11 residents with the lowest number of staff on night duty to provide assurance that there were sufficient staffing levels.

The registered provider did not make adequate arrangements for detecting and containing fires. For example:

The inspectors noted of the fire doors observed, some did not appear to meet the criteria of a fire door. Numerous doors had gaps along corridors, some office and store rooms were fitted with non-fire rated ironmongery and standard doors. The arrangement of doors used to provide en-suite access for residents from two separate bedrooms were found not to be fire rated doors. In the kitchen, serving hatches were noted to have gaps, were not fitted with door closers and a kitchen door did not close fully when tested.

A room labelled as a staff dining was found to be in use as a general kitchen freezer storage area, an office and an area to store staff belongings. Assurances were required from the provider and their competent fire person that this room was provided with the required fire rating. Furthermore, an internal glass hatch on a corridor located at the entrance lobby and numerous ceiling hatches did not appear to meet the required fire rating.

Fire detection was lacking in electrical servicing cabinets along a corridor. Delayed access to these areas was caused by the removal of handrails that were fixed to the corridor walls.

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre were not adequate. For example:

An urgent compliance plan was issued to the provider on both days of the inspection in regards to the location of the compartment boundaries in the designated centre and if they extended to the attic area to form complete compartment boundaries suitable for progressive horizontal evacuation. Documentation was submitted to the inspectors and a review revealed that a larger compartment existed in the centre. This was unknown to the provider and staff.

A designated fire exit along a corridor opened onto an external staircase that lead to a lower level. This fire exit and vertical evacuation route had not been tested by staff. Furthermore, there was no fire evacuation policy available when the church was in use by residents and the public. In addition to this, personal emergency evacuation plans (PEEPS) had not been updated since February 2023. Residents located in palliative/bariatric rooms were assessed to only need the assistance of one staff member in the event of an evacuation and the majority of evacuation aids were not available. This was found on both of the inspection days.

Some staff who spoke with the inspectors stated they would use a hoist to move residents in an evacuation. Care plans and PEEPS reviewed stated staff protect in-situ residents and wait for the fire brigade to arrive to evacuate. The use of hoists in the event of an evacuation is not acceptable nor is it acceptable to rely on the fire brigade to evacuate residents.

Therefore the inspectors were not assured that adequate arrangements were in place to evacuate, where necessary all persons in the event of a fire.

The displayed procedures to be followed in the event of a fire required a review by the provider. There was no indication of the location of fire compartments, fire escape routes, fire extinguishers or call points on the floor plans and a full basement level was not indicated on the floor plans for the centre. Furthermore, floor plans were not on display at the main fire panel and fire action notices that were displayed did not reflect the evacuation procedures.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents' assessment and care planning documentation and found that they were not compliant with regulatory requirements. For example;

- The care plans for residents using restraints did not detail the periods of duration and release whilst in use to guide staff in the provision of safe care.
- A resident who had unintentional weight loss had not been re-referred to a dietician in line with their care plan, management undertook to do so on the day of inspection.
- A resident with a diagnosis of epilepsy had a care plan in place, however it did not detail the care to be provided in an emergency situation to include for example, medication to be administered.
- Not all the care plans and assessments were updated within the required four month time-frame.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant

Compliance Plan for St Camillus Nursing Centre OSV-0000098

Inspection ID: MON-0043075

Date of inspection: 25/03/2024

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A fulltime, 9am to 5pm Monday to Friday, maintenance man will commence work on 17/06/24. • The new Maintenance Man will also facilitate an on-call service over weekends. • The Maintenance man will work off the Maintenance plan, which is created by the weekly environmental check & also the Maintenance log-book where staff report issues. • The current Maintenance man will continue until 01/07/24 to ensure a smooth transition. • The Kitchen cleaner will commence on 17/06/24. He will work Monday to Friday 18.00rs to 20.00hrs. In the interim the kitchen staff have received training in cleaning. • An external cleaning trainer is currently training all kitchen staff in the cleaning process and has also developed a Kitchen Cleaning Programme. Staff are also being trained in its use. • The Catering Supervisor is responsible for supervising the staff in the Little Kitchen. • Staff Nurse compliment has increased by two nurses to allow for two nurses day & night and holiday/sick cover. In the event of a nurse being unable to attend duty an agency nurse is engaged. • One CNM is Full-time and the second CNM works 24hrs. The ADON works 30 hours. Both CNM's and the ADON are supernumerary.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

• All kitchen staff have received training in Food Premises Cleaning on 10/06/24.
• The training consisted of setting a standard of competence and achievement for operators in food premises cleaning.
• The course covered: Best Practice in H&S tasks associated with the job. It enabled the staff to perfect their skills and carry out their tasks with confidence and work towards continuous improvement.
• Internal auditing will ensure that areas that need attention are addressed.
• A one to one, training session by the cleaning instructor took place on 12/06/24 with the new kitchen cleaner.

• The trainer is collaborating with the company supplying kitchen chemicals and equipment so they can be integrated into the training.
• In addition to this, "Control of Substances Hazardous to Health" training has also been organised through the company supplying the cleaning chemicals.

• Please see under - Regulation 27: Infection control

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Records are now in place to demonstrate the duration of restraints, including residents in high support chairs as identified on inspection.
• Staff are adhering to complete these records on a daily basis.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Storage Practices – A declutter of the building has taken place. Items that were not currently in use or necessary were discarded.
•
• Areas in the building containing electrical equipment are not being used for storage.

• Fire Doors have been inspected by Masterfire and repaired.

• Residents using Bariatric beds and are unable to weight-bear now have Evac-Pads close to their room to aid safe evacuation – PEEPS & Care Plans in place.

• The Fire Engineer visited on 12th June. We are awaiting his report on 21st June, which we will forward to the Chief Inspector.

• Regular evacuation drills are taking place to train staff in evacuation techniques, records of these are maintained.
• Daily inspections of Fire doors take place to ensure they are free from obstruction.
• At the Residents Monthly Meeting, fire safety is discussed.
• Weekly opening of fire doors takes place to ensure they are working correctly.
• Weekly Fire alarm check is in place – currently twice a week, see Fire Precautions below.
• Weekly Electrical Generator check is in place.
• Quarterly Fire Alarm service is in place.
• Quarterly Emergency Lighting testing is in place.
• Fire Extinguishers are serviced annually.

• All nurses have completed the Antimicrobial Stewardship course on HSELand.

• An Audit on 28/05/24 demonstrated that no resident is on prophylactic antibiotics.

• Skip-The-Dip information is now available and staff are adhering to the protocol to follow in the event of a suspected UTI.

• IPC National Link Practitioner for the Nursing Centre - We have contacted the local HSE Clinical Nurse Specialist for Infection Control. She informed us that the course is not currently available outside the HSE in this area. We have expressed an interest in undertaking this course when available.

• The ADON will continue to be the local link person and will keep staff updated with information on the HSE websites. We are following the IPC National Clinical Guideline No. 30, May '23 to update our policies and to guide staff in their practice.

• Chipped surfaces in the ensuite rooms are being repaired, to be completed by 21/06/24.

• Two new staff hand-washing sinks will be installed by the 30/06/24 to facilitate staff working in the older section of the building. One is at the laundry area to facilitate rooms 1 to 6 and one at room 11 to facilitate rooms 7, 8, 9. The clinical hand wash sinks will conform to HBN00-10 part C Sanitary assembles.

• Each sink will have an Integral back outlet, washing under running water therefore no plug, no overflow, wall mounted single-lever-action with single self-draining spout, TMV3- approved thermostatic mixing valve.

• Our Audit Schedule now includes a stand-alone IPC audit.

• Staff adhere to the policy of not wearing cardigans while in the clinical environment and that they are bare from the elbows.

• A dedicated storeroom for kitchen cleaning equipment has been identified outside and

is in operation, at the back of the kitchen.

• A professional deep clean of the catering area has been completed by an external cleaning company.

• Kitchen Cleaning System - Following a full assessment we have established a programme and timeframe for the introduction of a new kitchen cleaning system.

• A meeting was held with a cleaning Products & Catering Cleaning Trainer on 15/05/24. The following schedule has been agreed upon:

· Installation of Food Safe products by the end of June, including all cleaning chemicals and equipment.
· "Control of Substances Hazardous to Health" Training in the first week of July, followed by the:
· Introduction of the Cleaning Schedules and cleaning training for individual products.

Please see: Regulation 16: Training and staff development. This system will supersede everything currently in place.

• The dedicated catering staff toilet has signage in place to inform staff that it is for catering staff only.

• Bed-pan washers have the appropriate cleaning agent in place. Staff are using the equipment correctly.

• Bed makers now use a Colour-Coded linen skip and have been educated in its use.

• A fulltime, 9am to 5pm Monday to Friday, maintenance man will commence work on 17/06/24.

• The new Maintenance Man will also facilitate an on-call service over weekends.
• The Maintenance man will work off the Maintenance plan, which is created by the weekly environmental check & also the Maintenance log-book where staff report any issues.

• The current Maintenance man will continue until 01/07/24 to ensure a smooth transition.

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

• Residents' Contracts of Care are being amended and personalized to include the Social Charge, what services residents are receiving for the charge and that the resident (if possible) or their representative is in agreement with it. This will be completed by 14/06/24.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been revised to demonstrate the change in hours of the ADON, change in office purpose and Social Charge.

• The architect has redrawn the floor plans indicating the basement space under the chapel.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
• The Fire Policy has been reviewed and updated to include the possibility of a fire in the church.

• The fire procedure will be enacted. Staff will evacuate residents using progressive horizontal evacuation. The public will be told by the priest to leave by the fire exit.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• No items are stored in the Smoking Room.

• Moss on the paths has been removed.

• The socket in the sacristy has been repaired.

• The replacement of stained ceiling tiles has commenced. This will be completed by 28/06/24.

• Holes noted in the ceiling have been sealed.

• As mentioned in the report, access to the staff dining room. The dining room mentioned was and remains for the exclusive use of the catering staff. No other staff enter the kitchen.

• In relation to being one shower short: We have submitted an Application to Vary in regard to an additional shower in Room 27. We have reassessed the current staff toilet and shower room, which measures 4.3sqm, this is too small to convert into a resident shower.

• Residents have a choice of dining in two areas: Rebuschini Room; Residents' own rooms.

• Activities take place daily in three rooms: Rebuschini Room; Communal Dining/Recreation room 2. Sitting room 3.

• Staff dining takes place outside resident recreation times in Communal Dining/Recreation room 2.

• An additional call bell will be installed in the dining room by 01/07/24

• The hot water system has been inspected by a competent plumber and measures put in place to ensure an even distribution of hot water throughout the building.

• Potable water is available in two forms: 1. All rooms in the most recent extension have a drinking-water tap. 2. All residents have a fresh jug of drinking water daily.

• Staff files are stored, securely, in the Administrators office.

• Resident files are presently stored, securely, in the PIC's office, until the Fire Engineer has completed his assessment and advice given as to an alternative storage location.

• Toilets identified with only one Grab Rail now have two.

• Ceiling fans have been cleaned. The broken one has been replaced.

• The area under the church has been cleared of PPE and other items, as per photographs submitted.

• The storage area near the stairs has been decluttered and the fire doors cleared.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

• All nurses have completed the Antimicrobial Stewardship course on HSELand.

• An Audit on 28/05/24 demonstrated that no resident is on prophylactic antibiotics.

• Skip-The-Dip information is now available and staff are aware of the protocol to follow in the event of a suspected UTI.

• IPC National Link Practitioner for the Nursing Centre. We contacted the local HSE Clinical Nurse Specialist for Infection Control. She informed us that the course is not currently available outside the HSE in this area. We have expressed an interest in undertaking this course when available.

• The ADON will continue to be the local link person and will keep staff updated with information on the HSE websites. We are following the IPC National Clinical Guideline No. 30, May '23 to update our policies and to guide staff in their practice.

• Chipped surfaces in the ensuite rooms which were noted, have been added to the maintenance planner to be completed by 21/06/24.

• Two new staff hand-washing sinks will be installed by the 30/06/24 to facilitate staff working in the older section of the building. One is at the laundry area to facilitate rooms 1 to 6 and one at room 11 to facilitate rooms 7, 8, 9. The clinical hand wash sinks will conform to HBN00-10 Part C Sanitary assembles.

• Each sink will have an Integral back outlet, washing under running water therefore no plug, no overflow, wall mounted single-lever-action with single self-draining spout, TMV3- approved thermostatic mixing valve.

• Audit Schedule now includes a stand-alone IPC audit.

• Staff adhere to the policy of not wearing cardigans while in the clinical environment and that they are bare from the elbows.

• A dedicated storeroom for kitchen cleaning equipment has been identified outside and is in operation, at the back of the kitchen.

• A professional deep clean of the catering area has been performed by an external cleaning company.

• Kitchen Cleaning System - Following a full assessment of our needs we have established a programme and timeframe for the introduction of a new kitchen cleaning

system.

• A meeting was held with a cleaning Products & Catering Cleaning Trainer on 15/05/24. The following schedule has now been agreed upon:

· Installation of Food Safe products by the end of June, including all cleaning chemicals and equipment.
· "Control of Substances Hazardous to Health" Training in the first week of July, followed by the:
· Introduction of the Cleaning Schedules and cleaning training for individual products.

• Please see: Regulation 16: Training and staff development. This system will supersede everything currently in place.

• The dedicated catering staff toilet has signage in place to inform staff that it is for catering staff only.

• Chipped surfaces in the ensuite rooms are being repaired, to be completed by 21/06/24.

• Bed-pan washers have the appropriate cleaning agent in place.

• Bed makers now use a Colour-Coded linen skip and have been educated in its use.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A competent Fire Engineer completed a Fire Risk Assessment of the build on 12/06/24. His report will be available on 21/06/24 and will be forwarded to the Chief Inspector.

• A Wet Chemical Fire Extinguisher and a Fire Blanket is adjacent to the Deep Fat Fryer. Staff have been educated in their use.

• Initial written advice of the Fire Engineer, states that it is sufficient to maintain keys to locked rooms in Break-Glass boxes at the door of each room.

• Records of Ski-Sheet checks are up to date.

• The timber ceiling in the chapel has been included in the assessment of the Fire Engineer. It is expected that remedial work will need to take place. Quotes are being sought from two contractors. One is carrying out a site visit on 15/06/24 to assess the work required, the second on 18/06/24.

• A Chapel Fire Evacuation Policy is in place, added to our existing Fire Policy, and a risk

assessment performed, kept in the Risk Register.

• All electrical service cabinets are in unlocked rooms and none are being used as storage areas, awaiting the Fire Engineers report on 21/06/24.

• Regular evacuation drills are taking place, using the largest compartment and least number of staff available. A record of these is maintained.

• All PEEPS & corresponding Care Plans are up-to-date, detailing equipment needed, numbers of staff required and the capacity of the resident to follow evacuation instructions. No resident is for "Defend in Situ".

• Five new Evac-Pads are in place and placement of all Evac-Pads has been in accordance with individual residents PEEPS to ensure immediate access.

• The area under the church has been cleared as has the adjacent boiler room.

• A new Fire Assembly Point has been identified. This met the approval of the Fire Engineer on the day of inspection Signage is in place.

• All illuminated Fire Exit (Running man) signs now illuminate. They are now part of the weekly checks.

• All staff are adhering to the principle that the use of hoists to aid evacuation should never happen.

• Doors giving access to Ensuites between two separate bedrooms were inspected by the Fire Engineer on 12/06/27 and appropriate action will be taken depending on his report on 21/06/24.

• A competent fire company has fixed gaps found between fire doors on the corridors.

• The Fire Engineer has assessed the Catering Staff Dining Room next to the kitchen to ensure that it meets the required fire rating. He has also assessed the internal glass hatch in the entrance lobby and the numerous ceiling hatches to ensure they have the required fire rating; his report on 21/06/24 will detail his findings and remedial work will be taken.

• In regard to the Fire Exit leading to an external staircase leading to a lower level, the Fire Engineer has evaluated this and will report on the necessity of this exit, given its location.

• On written advice from the Fire Engineer, to mitigate risks while remedial work is undertaken, the following is in place:

· An additional Fire Alarm Test weekly
· Checking Laundry & Kitchen areas three time nightly
· Check all electrical boards daily.

· Items will not be stored near electrical boards.
· Two-Person Sign out sheet to confirm all laundry electrical equipment is off at the end of the day.
· Two-Person Sign out sheet to confirm all kitchen equipment is off at the end of the day.
· Staff are aware to turn off electrical equipment when not in use.
· Daily check of the boiler house.

• The architect has redrawn the floor plans to detail the location of fire compartments; fire escape routes; fire extinguishers and call points as well as the basement floor plan.

• The service cabinets along the corridors do not contain any electrical equipment, only the cisterns for the adjacent rooms. The Fire Engineers report on 21/06/24 will advise on these.

• The two Serving Hatches in the kitchen have been fitted with automatic fire-door closers linked to the Fire-Alarm System.

• Corridor Fire Doors have been assessed by the Fire Engineer on 12/06/24 - we await his report in regards to possible remedial work.

• "Oxygen in Use" signs are now used on residents' bedroom doors when oxygen therapy is being used.

• Up-to-date fire information posters are displayed around the Nursing Centre.

• The Emergency Lightening around the outside of the building - we engaged our electrician on 13/06/24. On-site visit completed on 14/06/24. Work to commence 24/06/24.

• Up-to-date fire maintenance records are available, including the quarterly inspection of emergency lighting.

• The area under the church has been cleared of PPE and other items, as per photographs submitted.

• A professional Fire Company are undertaking on-going works to ensure that all fire doors meet the standard.

• The storage area near the stairs has been decluttered and the fire doors cleared.

• One of the two Yellow Clinical Waste hoppers has been removed. The remaining one has been moved to a secure area, away from the windows & building.

• All external Oxygen cylinders are stored upright within a locked, ventilated cage.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• The two CNM's are supernumerary. They are ensuring that Care Plans as well as other individual assessments are updated within the required time-frames, including residents requiring external MDT assessments such as dieticians.

• Residents who use high support chairs have a change of position chart in place, including the frequency that the restraint is used.

• Residents with epilepsy have emergency medications in place to treat a seizure. Care Plans updated.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	17/06/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	12/06/2024
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	Not Compliant	Orange	15/07/2024

	purpose prepared under Regulation 3.			
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	Orange	01/09/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	06/05/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	21/06/2024
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for	Substantially Compliant	Yellow	06/05/2024

	all areas of care provision.			
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	06/05/2024
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.	Substantially Compliant	Yellow	14/06/2024
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are	Not Compliant	Red	21/06/2024

	implemented by staff.			
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	21/06/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	24/06/2024
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	21/06/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	21/06/2024
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 reasonably	Not Compliant	Red	08/04/2024

	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	Red	27/05/2024
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	08/04/2024
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Orange	06/04/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	06/05/2024
Regulation 04(1)	The registered provider shall prepare in writing, adopt and	Substantially Compliant	Yellow	06/05/2024

	implement policies and procedures on the matters set out in Schedule 5.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	27/05/2024
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).	Substantially Compliant	Yellow	06/05/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	03/05/2024

Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Substantially Compliant	Yellow	03/05/2024
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	03/05/2024