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 Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Shelbourne Road, Limerick
Type of inspection:	Unannounced
Date of inspection:	09 November 2021
Centre ID:	OSV-0000640
Fieldwork ID:	MON-0034408

About the designated centre

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

The designated centre of St Camillus' Community Hospital is located on the main campus of the hospital in Limerick city. The centre is operated by the Health Service Executive (HSE) and is registered to accommodate a maximum of 75 residents. Information provided in the statement of purpose for the centre describes care for people over 18 years of age across the range of abilities from low to maximum needs in relation to advanced age, vascular and neuro-injury, dementia and physical or psychiatric chronic illness. Care planning processes are in accordance with assessments using an appropriate range of validated assessment tools and in consultation with residents. Arrangements are in place to provide residents with access to activities and there is a variety of communal day spaces provided including a large activity area on the first floor. Visiting arrangements are in place and residents are provided with information about health and safety, how to make a complaint and access to advocacy services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	65

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 9 November 2021	08:30hrs to 16:30hrs	Sean Ryan	Lead
Wednesday 10 November 2021	08:00hrs to 15:30hrs	Sean Ryan	Lead
Tuesday 9 November 2021	08:30hrs to 16:30hrs	Claire McGinley	Support

What residents told us and what inspectors observed

Residents living in St. Camillus Community Hospital received good quality health and social care from a dedicated team of staff who knew them well and promoted their independence and quality of life.

The inspectors observed resident and staff engagement throughout the inspection that was polite, respectful and person-centred. Residents spoken with were complimentary of the quality of care they received from the staff and said they felt comfortable and safe living in the centre. Resident described the care as '10 out of 10' while other residents told inspectors that staff supported their choice in all aspects of their daily routine such as the time they get up from bed and how they would like to spend their day. Residents told inspectors that staff were interested in their work which made them feel well cared for. The only source of dissatisfaction expressed by some residents was the limited storage space in multi-occupancy bedrooms for personal belongings.

This unannounced inspection was carried out during the COVID-19 pandemic over a two day period. The inspectors arrived to the centre unannounced and were met by a member of the nurse management staff. Inspector were guided through the centres infection prevention and control screening procedure prior to entering the building. At the time of inspection, St. Camillus Community Hospital had not experienced an outbreak of COVID-19. No resident had tested positive for the virus and where there were suspect or confirmed cases among staff, this was managed in line with national guidelines and public health support. The inspectors acknowledged the challenging time residents, staff and visitors had been through and acknowledged the management teams effective procedures to minimise the risk of introducing the virus into the centre. Residents expressed their relief following the vaccination and the protection this now offered them.

Following an opening meeting with the person in charge, inspectors walked through each of the three units, Thomond, Sarsfield and Shannon, with the person in charge and met with a number of residents who were having breakfast in their bedrooms and dining rooms. Inspectors spoke with 10 residents and a small number of visitors over the course of the inspection. Through observations and discussions with residents, it was evident that the person in charge and residents knew each other well as they greeted one another during the walk around the centre.

At the time of inspection, significant building works were underway for the development of a new 75 bedded residential care facility. Many residents enjoyed watching the building works progress and were kept informed by management regarding its progress. Residents reported not being disturbed by the intermittent noise and inspector were assured that appropriate noise control measures were in place. Air purifiers were strategically placed throughout the Sarsfield unit to mitigate the risk of excessive dust impacting on the residents.

St. Camillus Community Hospital is a two story facility that is registered to provide care to 75 residents in both single and, predominantly, multi-occupancy bedrooms. Inspectors observed that a single bedroom on the Thomond unit had been removed to facilities external building works. This reduced bed capacity to 74. Inspectors observed a bed in a dayroom on the Shannon unit to facilitate isolation of a resident if required. Following a discussion with the management team, the bed was removed from the dayroom as it was not registered as a bedroom.

Some residents had personalised their private bed space with personal items of significance such as ornaments and photographs of family and significant events. However, in many multi-occupancy bedrooms this was not possible due to the location of the bed and curtain screens. Some residents told inspectors that they would like more privacy but had become used to sharing accommodation with others and the changes they made to their routine and compromising on television viewing as a result. Other residents whispered while engaging with the inspector so as not to cause disturbance to other residents in the bedroom.

There were appropriate handrails and grab-rails available in the bathrooms and along the corridors to support residents moving freely through the centre and maintain their safety. Access to outdoor garden space was restricted or inaccessible to residents living on the first floor of the premises. Some residents drew the inspectors attention to areas in their bedroom where plaster had dislodged from walls due to equipment hitting off walls and general wear and tear. Inspectors observed significant facility wide issue that required maintenance and repair in bedrooms, communal spaces and store rooms. Overall, inspectors found that further monitoring and oversight of the cleaning procedure was required. The inspectors observed many areas of the premises that were not cleaned to an acceptable standard and dust was evident on high surfaces in bedrooms and communal rooms. Following discussions with the management team, this had improved on day two of the inspection. Further findings are discussed under Regulation 27: Infection control.

Residents confirmed to inspectors the availability of snacks and drink at their request. Residents were complimentary of the quality of the food and were provided with a choice daily for their meals. Inspectors had the opportunity to observe the residents dining experience on each unit. Staff were available to provide support and assistance to residents. However, inspectors observed that the dining experience in some of the units required review to ensure a relaxed, pleasant and person-centred atmosphere was provided for residents. For example, music was excessively loud and uncomfortable for some residents whom the inspectors spoke with.

Over the two days of inspection, most residents were observed enjoying the company of staff and other residents in communal day rooms on each unit while some chose to remain in their bedroom. An activities schedule on display for residents and staff this this aligned with the activities observed on the days of inspection. Inspector observed that the activity schedule was communicated to staff at the morning handover to allow staff to inform residents of the daily schedule as they assisted residents with their personal care needs. Activities on the day of inspection included movies and music. Inspectors spent some time observing the activities that were held and noted improvement in the provision of activities for

residents since the previous inspection.

Residents and visitors expressed their delight that visiting had been resumed in the centre. Visitors were observed coming into each unit and meeting with residents in designated visitor rooms and unused communal space. Inspectors observed that some visits were interrupted due to the location of the visiting area near main access doors to one unit.

Residents confirmed that they were kept informed about the ongoing building works, changes to visiting guidelines and their feedback was sought on a monthly basis in resident forum meetings. Residents were satisfied with the activity programme and while there was one activity coordinator on duty each day, all staff contributed to ensure a quality activity programme was provided to residents. Residents had access to religious services weekly in the centre or could listen to mass on the radio. Daily newspapers and magazines were readily available for residents.

The following section of this report outlines the findings in relation to the capacity and management of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

The findings from this inspection were that the registered provider had not ensured that the service provided met the needs of the residents living in the centre, particularly in terms of the arrangements for a suitable environment, infection control, personal accommodation and storage. Although some improvements had been made, namely the provision of consistent activities for residents, oversight of the issuing of contract of care and notification of incidents to the Chief Inspector, the provider had not adequately addressed many previously identified regulatory non-compliance's. For example, the constraints of the premises and multi-occupancy bedrooms continued to impact on residents privacy, dignity and quality of life. The provider had taken a proactive approach to ensure that the designated centre was fit for purpose and an extensive building programme had commenced that would consist of three 25 bedded residential units with each unit having 21 single rooms and two twin rooms and additional communal and private space for residents with access to secure outdoor gardens.

Inspectors found that improved oversight and monitoring was required in:

- Staff training, supervision and development.
- Risk identification
- The premises
- Fire safety
- Infection prevention and control (IPC).

- Residents rights.

This was an unannounced risk based inspection conducted over two days by inspectors of social services to:

- Monitor compliance with the Health Act (2007), as amended and the Regulations and Standards made thereunder.
- Follow up on the actions taken to address non-compliances found on the previous inspection in February 2020.
- To review the actions taken to comply with condition 5 of the registered providers registration.
- To review the centres infection prevention and control standards and the COVID-19 preparedness plan.

Inspectors found that St. Camillus Community Hospital had an established governance and management structure with defined lines of authority, accountability and responsibility. However, inspectors found that the management systems to monitor, evaluate and improve the quality of the service required strengthening. The monitoring and oversight by management was not effective in identifying deficits in specific aspects of the service and where management had identified some deficits and escalated them to senior management, action had yet to be taken. For example, the requirement for a housekeeping supervisor.

The Chief Inspector had renewed the registration of this centre in June 2021 with two additional restrictive conditions attached to the registration. Condition 5 was aimed at improving the privacy, dignity and quality of life for residents living on Thomond unit through the provision of additional showering facilities. The registered provider was required to comply with this condition by 30 September 2021. On inspection, inspectors observed that the registered provider, the Health Service Executive (HSE), had complied with the requirement of condition 5. The purpose of condition 4 was to ensure that each residents' accommodation had an area of not less than 7.4 metre squared of floor space to include space occupied by a bed, a chair and personal storage. The registered provider was required to reduce the occupancy in bedroom 3 on the Shannon unit from four beds to three beds in order to comply with the requirements of S.I. No 293/2016 due to come into effect on 01 January 2022. The person in charge confirmed that the reduction in occupancy of bedroom 3 would be completed in the weeks following the inspection.

The management team consisted of the head of service, general manager and the person in charge. The person in charge was supported by two assistant directors of nursing who worked in a supernumerary capacity. Their role included overseeing staffing resources, monitoring the clinical key performance indicators and supporting the person in charge to discharge her duties and regulatory responsibilities. Inspectors found the management team to be responsive. Non-compliance with regulations found on the days of inspection were, where possible, rectified immediately. The person in charge had clinical oversight of the service provided and information was communicated on a daily basis from the clinical team in terms of residents who were at risk of malnutrition, incidents and wound care. Formal weekly clinical nurse manager team meetings were held and clinical indicators, such as

those described above, were discussed in greater detail. This information was then further analysed in the governance and management meetings and included additional items such as risk, infection prevention and control and fire safety. There was evidence of ongoing communication with staff in the minutes of meetings reviewed by inspectors and evidence of ongoing consultation with project managers for the new building. An audit schedule was in place that monitored and analysed falls, wound care, clinical care documentation and hygiene and infection prevention and control (IPC). However, inspectors found that audits were not consistently effective in addressing areas of non-compliance or informing quality improvement. For example, an environmental audit completed in January 2021 identified many issues that were actioned and completed by a responsible and accountable person, however inspectors found these issues continued to persist in the centre in areas such as environmental hygiene and the provision of facilities to promote a high standard of infection prevention and control. Inspectors observed that some risks identified in audits were escalated to senior management within the HSE but were not acted upon in a timely manner. Systems were in place to ensure notifiable events were reported to the office of the Chief Inspector within the required timeframe. The annual review of the quality and safety of the service for 2020 had been completed and shared with residents and a corresponding quality improvement plan was in place.

On the days of inspection, there was significant building works underway in the development of a new purpose built facility. Consequently, these building works had resulted in some structural changes to the designated centre, such as the loss of a single bedroom on the Thomond unit and the installation of modular sections of building that contained toilets and store rooms. An oversight group was in place to maintain clinical governance over the impact of the build on the current residential area. Meetings were held weekly to discuss the progress of the building works and implications to the care of residents. Risk assessments and phased building plans were in place with controls to mitigate the risk and disturbance to residents daily life. However, the effectiveness of these controls required ongoing review to ensure actions taken were implemented and effective in protecting residents from risk. Enhanced cleaning procedures formed part of the control measures in place. However, the inspector observed that the cleaning procedure was not being effectively monitored or consistently implemented and this impacted on the overall standard of environmental hygiene and cleanliness.

The inspector reviewed the centres COVID-19 and preparedness plan. This document was reviewed frequently by the person in charge and detailed the procedures to be initiated in the event of an outbreak. Key personnel involved in overseeing the implementation of the plan were identified such as the COVID-19 lead. Designated isolation areas had been identified on each unit and a plan in place for surge capacity if necessary.

On the day of inspection, there were 65 residents living in the centre. The team providing direct care to residents consisted of a team of nurses and healthcare staff. Multi-task attendants were rostered on each unit daily and assigned to the role of catering duties, laundry and housekeeping. Each unit had a clinical nurse manager on duty to supervise the care provided to residents and they reported to the

assistant directors of nursing and person in charge. There was an appropriate number and skill mix of staff on duty to meet the assessed needs of the residents.

Record-keeping and file-management systems were in place and records were made available to the inspectors for review. The inspector reviewed a sample of staff personnel files and they were found to contain the information required by the regulations with the exception of one file that did not contain two employment references. Since the previous inspection, the provider had implemented systems to ensure residents admitted to the centre for respite care were issued with a contact of care.

Staff were supported and facilitated to attend training relevant to their role such as fire safety training, cardio-pulmonary resuscitation (CPR), infection prevention and control and the safeguarding of vulnerable adults. Staff were knowledgeable in their role and responsibility in recognising and responding to abuse, fire safety and the procedure to initiate should a residents or staff display symptoms consistent with COVID-19. The person in charge confirmed that staff training needs were under review and some training specific to dementia care was outstanding. Inspectors found that this had been risk assessed by the person in charge. Inspectors observed a disparity between the theory of some training and what was observed in practice in the centre. For example, inspectors found that the response to a false fire alarm activation was not as described by staff to the inspectors. The system of supervising staff required improvement to ensure the theory of learning in regard to infection, prevention and control was implemented in practice to support the centres ongoing IPC measures. Some staff were not aware of the policy on cleaning and a review of the schedule 5 policies evidenced gaps in the review dates of these policies.

The person in charge was responsive to the receipt and resolution of complaints. The complaints procedure was displayed prominently in the centre and detailed the process and procedure involved in making a complaint. Residents, staff and visitors confirmed that there were aware of the personnel whom they could speak to if they were not satisfied with any aspect of the service and were confident that any issue raised would be resolved promptly.

Regulation 15: Staffing

There were sufficient numbers of staff with the necessary skills and competencies to meet the needs of residents and which reflected the size, layout and purpose of the service.

Judgment: Compliant

Regulation 16: Training and staff development

Further analysis of staff training needs was required to ensure staff were appropriately trained relevant to their role.

Training specific to dementia care remained outstanding since the previous inspection of the centre in 2020. The requirement to complete this training was discussed with the management team in the context of the high number of residents living with dementia in the centre.

The training records for staff in regard to infection prevention and control did not detail the specific aspects covered in this training and therefore it could not be determined if all staff had received training in , for example, donning and doffing of personal protective equipment.

Further areas that require improved oversight and supervision include:

- Supervision of the cleaning procedure.
- Supervision of the role of the multi-task attendants (MTA). For example, inspectors observed that MTA's were required to carry out multiple duties that included laundry duties, cleaning and assisting with mealtimes. Consequently, hours dedicated to cleaning in each unit were not defined.
- There was no induction records for staff who perform housekeeping and decontamination duties and there was no assessment of competence to carry out these duties.

Judgment: Not compliant

Regulation 21: Records

Record-keeping and file management systems required improvement to ensure records were appropriately maintained and available for review. This was evidenced by:

- A staff file did not contain two written references as required by Schedule 2 of the regulation.

Judgment: Substantially compliant

Regulation 23: Governance and management

While it was evident that direct care was delivered to a good standard, inspectors found that further development of the management systems in place to monitor, assess and improve the quality of the service required improvement. For example:

- While auditing systems had identified issues with the premises and infection

prevention and control in January 2021, these issues had not been resolved. Quality improvements plans identified actions as completed when they continued to persist.
- The provider had reduced the bed occupancy in the centre but had not submitted an application to vary a condition of their registration.
- There was poor oversight of the systems to monitor and implement the cleaning schedule and procedure as per the centres cleaning policy.

The system of risk identification and reviewing risk required improvement. The inspector observed a number of risks on the day of inspection that required review. For example:

- The risk associated with ongoing building works required review.
- The risk associated with inadequate facilities to promote a good standard of infection, prevention and control.
- The fire risk associated with the designated smoking area for residents.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Inspectors followed up on the actions taken following the previous inspection in regard to contacts for the provision of services for residents receiving respite care.

Each resident in the centre had a signed contract of care in place that met the requirements of the regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

All incident, categorised as notifiable events, were reported to the Chief Inspector in the required format and within the specified time frame in accordance with the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was prominently displayed in each of the three units in the centre. A complaints log was maintained on each unit and a log was held by the

person in charge. A review of the complaints log evidenced that:

- A record of all complaints received was maintained.
- An accountable person took responsibility for resolving the complaint and complaints concerns were acknowledged.
- The actions taken on foot of the complaint were documented with the complainants satisfaction with the actions taken.

There was evidence of learning from complaints to inform quality improvements in the service.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of schedule five polices provided to the inspectors for review were national policies and were not adopted, reviewed or updated in accordance with the requirement of the regulation. For example:

- The Risk Management policy was dated 2017.
- The prevention, detection and response to abuse policy was dated December 2014.

While Schedule 5 policies were available on each unit, they were not always accessible to all staff as they were locked in an office accessible to nursing staff only. Some staff whom the inspector spoke with were not familiar with the policies and procedures.

Judgment: Substantially compliant

Quality and safety

Inspectors found that residents in this centre received good quality healthcare and support from staff who knew each residents individual needs and preferences. However, the governance and management required strengthening in order to support the quality and safety of the service.

Inspectors reviewed a sample of six resident's files. Each resident had a comprehensive assessment completed on admission to the centre that informed the development of their care plans. Validated assessment tools were used to assess residents dependency needs, risk of falls, risk of impaired skin integrity and nutritional risk screening. Social activity needs were assessed and this informed the development of person-centred activities care plans. While it was evident that staff

knew residents individual care needs in detail, further improvement was required to ensure that residents changing needs and prescribed care interventions were updated into the residents care plans. This is discussed further under Regulation 5: Individual assessment and care plan.

Systems were in place to ensure accurate clinical and social needs information in regard to each resident was communicated to staff. Inspectors observed a daily report in use by the clinical staff that detailed residents specific care needs in regard to nutritional requirements, level of assistance, mobility aids required for a safe transfer and wound care. There was a low incidence of pressure wounds in the centre. A review of wound care records evidenced that nursing staff provided evidenced based care in the management of wound.

Residents had unrestricted access to a general practitioner and where further health and social care professionals expertise was required, there was a referral system in place. This included referral and access to dietician services, speech and language, physiotherapy and psychiatry of later life. The person in charge informed inspectors that the centre promoted a restraint free environment through an ongoing initiative to reduce the use of bedrails in the centre and this was evidenced in the documentation provided to inspectors for review. Where a residents requested the use of bedrails, alternative were trialled at first followed by a risk assessment and a multi-disciplinary approach to assessment inclusive of the residents wishes and needs. Inspectors observed staff engaging with residents who had responsive behaviours and engagement was respectful and non-restrictive. As found during the previous inspection, further improvement was required in the assessment of residents who had responsive behaviours.

Advanced care plans were in place in regard to residents medical resuscitation status and this information captured the residents wishes in regard to their end of life care. Family and friends were support to be with residents as they approached their end of life. Staff were observed to provide compassionate care to residents and their family during this time and palliative care services were available to provide additional support to residents on their end of life journey. The provision of single rooms for residents who wished for complete privacy during end of life care continued to present a challenge and this was further impacted upon due to the need for single rooms for isolation purposes. Where possible, the person in charge confirmed that a single room was reserved for residents receiving end of life care.

The management team had implemented measures to reduce the risk of the virus entering the centre in addition to implementing the guidance published by the Health Protection Surveillance Centre. Discussions with staff and management evidenced that COVID-19 preparedness plans were reviewed frequently and each unit was prepared to initiate procedures in response to a suspect or confirmed case of COVID-19. Inspectors identified many examples of good practice in the prevention and control of infection. This included:

- Twice daily symptom monitoring of residents and staff.
- Ample supplies of personal protective equipment.
- Alcohol hand gel dispensers were available throughout the centre and were

observed to be used frequently by staff.
- Appropriate signage was in place to prompt staff, visitors and residents to perform frequent hand hygiene.

Notwithstanding the positive measures observed during the inspection, Inspectors found that the cleaning procedure required further oversight to ensure a good standard of environmental hygiene supported the centres infection prevention and control measures. Cleaning schedules and records of deep cleans contained gaps and were not effectively monitored. Further findings are discussed under Regulation 27: Infection control and the inspectors acknowledges that on day two of the inspection, action had been taken to address some non-compliance found with IPC and the cleaning procedure.

As identified on the previous inspection, management and staff were aware of the impact the current premises had on the quality of life for residents and non-compliance's from the previous inspection persisted in regard to inadequate personal and storage space for residents. The inspectors noted that storage space was limited and allocated wardrobes were extremely small for residents to store personal possessions. There was inappropriate storage of equipment observed in toilets and bathrooms. Further findings are discussed under Regulation 17: Premises.

Inspectors reviewed the centres testing and maintenance records in respect of fire safety. There was evidence of daily and weekly fire safety checks. The fire equipment and fire alarm had been serviced. Fire exits were observed to be free of obstructions. The person in charge confirmed that she continued to assess the evacuation needs of residents and each resident had a personal evacuation plan on file. All staff had completed fire safety training but some staff spoken with had been involved in fire safety evacuation drill. Inspectors observed a number of fire risks that were brought to the attention of the management team in the day of inspection.

Residents rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Residents were observed to be engaged in meaningful activities throughout the day. Inspectors acknowledged improvement in the provision of activities for residents and residents confirmed that all staff contributed to providing meaningful activities and engagement. Residents were familiar with the activity schedule on display and could choose what activity they wanted to attend or could choose to remain in their bedroom and watch T.V or chat with staff. Residents had access to religious services weekly and could access mass daily via radio. Staff in the centre made efforts to ensure residents privacy and dignity needs were met. Personal care and assistance was provided discreetly behind privacy screens and bedroom door were closed. However, the nature of the multi-occupancy bedrooms did not always ensure that residents privacy and dignity needs were met to an optimal standard.

Regulation 11: Visits

Residents were supported to maintain personal relationships with families and friends. The centre was facilitating visits in line with the current Health Protection Surveillance Centre (HPSC) COVID-19 visiting guidelines.

Visitors were guided through the centres infection prevention and control procedures prior to entering the centre and systems were in place to ensure residents, visitors and staff were protected.

Residents in multi-occupancy bedrooms were unable to receive visitors in private. As a result, residents were observed receiving visitors in communal areas, designated for visiting, near main entrance door to units. Some residents found this arrangement unsuitable as visits were interrupted by people passing through and the ambient and surrounding noise caused disturbance.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Inspectors observed many bedrooms where residents had inadequate space to store clothing and other personal possessions. For example:

- Personal clothing stored in bags and boxes beside lockers
- Clothing was observed hanging on the side of single wardrobes in multi-occupancy bedrooms or on top of storage units.
- Due to limited storage space, some residents 'summer' clothing was stored in boxes in store rooms and this created a risk of clothing becoming misplaced or damaged and restricted residents access to their personal clothing.

Judgment: Not compliant

Regulation 13: End of life

While compassionate end of life care was provided to residents, the facilities available for residents on their end of life journey, and their families, continued to present a challenge due to the majority of resident being accommodated in multi-occupancy bedrooms. As a result, residents did not always have the option of a single room should they wish for complete privacy with their family as they approach their end of life.

Judgment: Substantially compliant

Regulation 17: Premises

Further improvements were required in regard to the premises and infection prevention and control, which were interdependent. For example:

Inspectors observed facility wide issues related to maintenance.

- Several surfaces, finishes and flooring in the centre were worn and poorly maintained and as such did not enable effective cleaning and compliance with infection prevention and control best practice.
- Day rooms on the Thomond and Sarsfield unit had evidence of water ingress damage, damp as a result of external building works. This was brought to the attention of the management team who cleaned and repainted the area by day two of the inspection.
- Walls, doors, skirting boards and window sills were damaged, with paint chipped.
- Gaps between the floors and skirting boards resulted in a build-up of debris.
- Ventilation in one bathroom on the Shannon unit was not working and this resulted in a strong unpleasant odour. Ventilation in sluice rooms had been disabled.

Equipment was not well maintained. Inspectors found that:

- Some commodes were damaged, worn and cracked. Wheel castors were heavily rusted and were not clean.
- Hoists were not clean and service and validation histories were not visible on equipment.
- Bed frames were not clean and wheel castors were visibly unclean.
- Foot pedal operated bins were heavily rusted and not amenable to cleaning.
- Catering equipment required maintenance, repair and cleaning.

There was inappropriate storage of equipment found throughout the centre.

- A dayroom on the Thomond unit had been partially screened off and was used to store equipment such as mobility aids, mattress and boxes of PPE.
- Wheelchairs and mobility aids were stored in a bathroom in the Shannon unit.
- Store rooms had excessive amounts of stock including nutritional supplements, continence wear and clinical equipment stored on the floor.
- Kitchenette store rooms contained catering goods and consumables, cleaning chemicals and cleaning equipment.

As identified in the previous inspection of the centre in 2020, the current premises did not conform to the matters listed in Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. Examples of this included:

- Multi-occupancy bedrooms did not support residents' privacy and dignity.
- Residents were not always afforded space to have a chair beside their beds.

- Access to outside communal space was inadequate.

Judgment: Not compliant

Regulation 18: Food and nutrition

Inspectors found that improvements were required in the residents overall dining experience and the serving and presentation of meals to residents. For example:

- Inspectors observed that modified consistency foods were stored in tinfoil containers outside of a temperature controlled environment.
- The presentation and serving of modified consistency diets required improvement to ensure they are presented in a way that is attractive and appealing, in terms of flavour, texture and appearance.
- There were missed opportunities for staff to communicate, engage and interact with residents during mealtime in the dining room due to loud music that some residents found distracting and uncomfortable.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy contained the risks and actions taken to mitigate the risks identified and required by regulation 26(1)(c). The policy provided to inspectors for review was last updated in 2017 and this is actioned under Regulation 4: Written policies and procedures.

There were systems in place for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.

The non-compliance found with the system of risk management is actioned under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 27: Infection control

A number of issues that had the potential to impact on infection prevention and control measures were identified during the course of the inspection. Inspectors observed the following risk areas:

- Cleaning trollies were visibly unclean and there was no record of equipment cleaning or decontamination.
- Inspectors observed a number of occasions where face masks were not worn in accordance with current guidelines.
- Several items of resident equipment and furniture observed during the inspection, including commodes, hoists, bed frames and wheel castors, were visibly unclean.

The environment, including resident accommodation, required significant improvement in the implementation of the cleaning procedure as detailed in the cleaning policy. For example:

- Dust was visible on the top of door frames and curtain rails on the Sarsfield unit.
- Windows throughout the building were not clean.
- Store room and sluice room floors were not clean on inspection.
- Ventilation fans were visibly unclean in bathrooms, shower rooms and sluice rooms.
- The floors around sinks and toilets were stained and not visibly clean.
- Shower guards were encrusted with organic matter.

Catering equipment and facilities were not maintained to an acceptable standard. For example:

- Equipment such as dishwashers were heavily soiled with organic matter.
- Kitchenettes were not clean on inspection as evidenced by a build-up of dust and debris on floor edges, corners and behind equipment. Wall tiles were not clean.
- Wheel castors on kitchen equipment were heavily rusted.

The sluice rooms did not facilitate effective infection prevention and control measures. For example, a sluice room was overstocked with equipment that obstructed access to the hand wash sink and some sinks did not meet the required specifications.

Judgment: Not compliant

Regulation 28: Fire precautions

Further monitoring and oversight of fire safety precautions was required. Inspectors observed the following fire risks:

- During a fire alarm activation, one fire door did not release while another was wedged open and could therefore not close. This compromised the function of the fire door in protecting residents and staff from the risk of fire.

- Cross corridor fire doors on the Shannon unit did not release when the inspector attempted to do so.
- A sluice room door was wedged open with a waste bin.
- Floor plans displayed throughout the centre had not been updated to include structural changes as a result of building works.
- A temporary smoking area was established on a small balcony in the Thomond unit. This area had not been appropriately risk assessed and created a significant risk. For example, cigarette butts were observed on the roof below this balcony.
- Fire drill records evidenced evacuation drills of one room but did not progress to a full compartment evacuation. A fire evacuation drill of the largest compartment was not available for review when requested but was completed and provided to the inspector on day two of the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors reviewed a sample of residents assessments and care plans and observed that improvements were required to ensure that each residents' care plan accurately reflected the assessment of their needs. This was evidenced by:

- Care plans were not in place for residents receiving antibiotic therapy and subcutaneous fluids.
- A care plan was not updated to reflect a resident identified as nutritionally at risk with reduced dietary and fluid intake. The care plan described the resident as a low risk of malnutrition.
- A falls care plan for one resident did not identify that the resident was a high risk of falls despite sustaining a high number of falls in a short period of time.
- Care plan in regard to pain management did not detail the medication used to alleviate pain or discomfort, the frequency of administration or the potential side effects to monitor when using such medication.

The system of reviewing care plans requires improvement in regard to the consultation process with residents on the revision of care plans. For example, some residents whom the inspector spoke with were not aware of their individual care plans and the documentation to support the consultation process was not consistently maintained.

Judgment: Not compliant

Regulation 6: Health care

Resident were provided with timely access to their General Practitioner and health and social care professionals such as physiotherapy, dietician, speech and language therapy and psychiatry of later life.

There was good evidence that advice and recommendations made were acted on in a timely manner which resulted in better outcomes for residents.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

As found on the previous inspection, further improvement was required in the assessment of residents that had responsive behaviours. While an antecedent, behaviour and consequence (ABC) chart was in place to identify triggers of responsive behaviour, there were gaps in the documentation in regard to the interventions employed by staff to de-escalate episodes of responsive behaviours.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Some residents in multi-occupancy bedrooms did not have a choice of television viewing as they shared a television with other residents. In some cases, privacy screens, when drawn, obstructed the view of the television.

Some residents felt unable to engage in private conversation without being overheard or potentially causing disturbance to others in their bedroom.

While privacy screens provided visual protection, they did not adequately protect the privacy of residents in relation to the conduct of personal activities and communication. These screens provided little or no protection from the noise and odours that a resident might experience in multi-occupancy accommodation.

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	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Not compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Camillus Community Hospital OSV-0000640

Inspection ID: MON-0034408

Date of inspection: 10/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A training needs analysis has been undertaken to identify the gaps following inspection. The following training has been identified as required and subsequent action plan put in place. CleanPass training has been organised for 19th, 20th and 21st January 2022. This will help address concerns highlighted under Regulation 16, Regulation 23, Regulation 4, Regulation 17 and Regulation 27. Dementia training will commence in December 2021, inclusive of all relevant grades of staff and will be completed by end March 2022. Fire safety training dates are organized for Dec 2021, Jan, Feb, March 2022. Procedure to follow in the event of a fire activation has been reviewed and recirculated. AMRIC is completed on HSELand and covers the 5 mandatory modules including basics of IPC, Standard/Transmission based precautions, hand hygiene, PPE and antimicrobial stewardship thus clearly identifying the training undertaken by all staff. Hand hygiene training ongoing with IPC Link practitioners and IPC lead.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A full review of files has been commenced to ensure that the regulatory documents are available for inspection at any time. All new files are checked as they are received. A new process has been put in place to ensure that if a file needs to leave the nursing office, the necessary documentation for inspection will be retained on site. This will be completed by 31st of March 2022	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of the oversight processes has been undertaken. Our Clinical Nurse Managers (CNMs) have been mentored on their specific requirements to ensure oversight specifically in their areas of responsibility. The Assistant Directors of Nursing (ADONs) have defined areas of responsibility also to ensure that the day to day operations of the hospital are being carried out in line with best practice and to review audit findings and outcome to ensure corrective actions were maintained. The Application to Vary has been submitted on 09/12/2021 with revised Statement of Purpose and floor plans reflective of footprint of designated center. The monitoring of the cleaning in the center has been designated to the ADONs and this is incorporated into the daily observational round of the hospital. There is a new build specific risk register in place and this is reviewed and updated in conjunction with the Health and Safety Officer and the Risk Advisor for the hospital. Risks associated with the premises and associated challenges with the existing build have been reviewed by the IPC Link Advisor, Risk Advisor and Health and Safety Officer. This risk remains high due to ongoing environmental challenges which will be addressed with the completion of the new hospital. In the interim all measures are being put in place to optimize the existing building to reduce risk such as increased maintenance and painting schedule.
The risk assessment in place for the two residents who smoke in St Camillus have been reviewed and are being monitored on an ongoing basis to proactively identify any increased/changes in the identified risk. The completion of this risk assessment was supported by our Health and Safety officer.

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 Schedule 5 policies are being reviewed. A copy for each unit is in place and the Clinical Nurse Mangers have been advised to ensure that all staff working in their area of responsibility have signed off on existing policies. The process for issue of reviewed polices has been discussed with clear responsibility lying with the CNM to ensure staff are aware of the changes and sign off on policies in a timely manner. The policies identified by the Inspectors were reviewed and updated immediately after our inspection.

Regulation 11: Visits	Substantially Compliant
Outline how you are going to come into compliance with Regulation 11: Visits: We have reviewed the visiting designated areas. Where possible, residents receive their visit in the family rooms assigned to each unit. Where this is not possible due to increased need for extra visits, families and residents are included in the decision on where visits should be undertaken and care is given to optimize the privacy of each residents visit. Open communication processes are in place to promote any resident or family member to bring a concern about visiting to the attention of either the Unit CNM or the Nursing Office.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: The limitations of the environment have been reviewed with respect to access and storage of personal belongings. When increased storage has not been possible due to building restrictions, extra storage in designated areas with clear demarcation of the items and more robust storage boxes have been sourced to minimize risk of damage or loss. Care plans reflect discussions with resident and family on storage of items	
Regulation 13: End of life	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: End of life: As outlined during our inspection, prioritization is given to fulfilling the identified wishes of our End of Life residents including access to single room facility where preferred. Every effort is made to accommodate the needs of our residents and families during End of Life.	
Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: A maintenance and painting programme has been agreed and commenced within the hospital to optimize the environment and minimize the impact of the current environmental challenges around cleaning and IPC requirements. Where required, assistive equipment, such as commodes, have been replaced. Bins and catering equipment have been reviewed and, where necessary, equipment has been deep cleaned or replaced. The service records of our hoists are in place and the issue around the signage on the hoists has been brought to the attention of our maintenance department and contract service technicians to ensure labelling is clearly visible on all hoists. Areas identified for decluttering during the inspection were addressed immediately while Inspectors were on site. Ongoing environmental checks are completed daily by ADON and CNMs to prevent further issues developing. Store rooms have been tidied and overstock has been stored in designated areas to ensure stock is readily available and maintained in appropriate areas. The kitchenette store areas have been defined with no overlap of cleaning equipment and consumables. Again this is checked daily by CNMs and ADON to ensure compliance is maintained. Defined residents' personal space has been identified where curtains need to be resited to allocate more even distribution of space availability in multi-occupancy room. This will be completed by end Jan 2022. Access to available out door space is being optimized while new build is ongoing and there is construction traffic and restrictions in place.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: The Catering Manager has reviewed the practices around modified diet delivery within our units. Training has been given to Catering Attendants to ensure a standardized approach is taken in line with best practice. Training included presentation of meals and promotion of delivering food in a manner that is pleasing to our residents. Dysphagia training has also been completed and is being rolled out to all relevant staff. This will be completed by end of February 2022. A dining room experience audit has been completed in all dining areas, including observational audit. Included in the food management training is a section on ensuring that dining experiences are optimized with the units inclusive of awareness of the impact of back ground music. This has been discussed with residents in monthly resident meetings with open discussion around preferences documented.	

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Infection control measures and responsibilities associated with the clinical oversight of this essential element of care practices has been reviewed and discussed with our management team. Responsibility has been assigned to the ADONs for our units to ensure that environmental monitoring is being undertaken daily in conjunction with the CNMs of the individual units. An environmental audit undertaken by IPC has a comprehensive action plan in place to address environmental risks.

The Director of Nursing and Head of Maintenance have assessed the physical environments in each unit from a general maintenance perspective and an agreed schedule of works (including window cleaning) has been put in place. These works are due to commence week of 13th December 2021. Meetings have been held with our teams including CNM's, Staff Nurses, Healthcare Assistants and Multitask attendants to ensure that daily work processes support defined roles for each person to avoid cross over of duties. CleanPass training has been booked for 19th,20th and 21st of January 2022 . An induction checklist has been developed and will be used in conjunction with CleanPass training. We will have 2 IPC Link Practitioners within the Hospital, training has been completed. They will support IPC needs within each of our units including undertaking of auditing. A third member of staff has been identified for the next IPC Link Practitioner programme in Spring 2022.

The Catering Manager has completed audits on each of the kitchenettes and the findings have been circulated and actioned. Dust monitoring audits are in place and spot checks by ADON and CNMs are being undertaken to ensure effective practices are in place to manage increased dust from construction on site. A system has been put in place to provide assurances in relation to the decontamination of patient care equipment and a visible process around assurance of undertaking is in place.

The designated centre participates in national monthly collection dataset on antibiotic use and the prevalence of multi drug resistant organisms/ infections to identify and tract trends within our hospital and submitted nationally. There are quarterly IPC committee meetings in place and these are used as a platform to disseminate learning to all units following any incident e.g. outbreak. Old and worn equipment has been identified and replaced.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All fire doors are checked daily. There is heightened awareness of the need to ensure that fire doors and exits are maintained daily. This is included in the daily environmental checks. The process for staff to follow in the event of activation of fire alarm has been

recirculated and highlighted at safety pause in all units. Simulated fire evacuation drills with night time staffing levels are ongoing. Compartments have been prioritized for undertaking of fire drill with associated times looking at key compartments requiring the evacuation of the most numbers of residents or specific challenges in respect of evacuation. Floor plans are being updated by an external fire safety firm. Risk assessments in respect of two residents who smoke have been reviewed and updated to reflect the risks associated with the environmental challenges of the building. The fire doors in Shannon Unit were checked and activated appropriately when the release button was used. This is checked periodically.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: Our CNMs are aware of the need to continue to ensure that care plans are updated in line with current needs of our residents. This is being spot checked and audited to capture any deficits in documentation. Care planning refresher training has been requested through CNME.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: Dementia training is being rolled out across the units with training planned to be completed by end of Quarter 1, 2022. The use of ABC charts and managing behaviors that challenge is explored, outlined and supported. Auditing is ongoing both peer to peer and scheduled to evaluate and address deficits in care processes and documentation around behaviors that challenge.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

Access to TV has been reviewed to ensure that residents who wish to have access to TV are facilitated with same. There is a private family room for visits and staff have been reminded of the need to promote private discussion with our residents taking into account the challenges present through multi occupancy rooms.

Staff have been reminded of a need to maintain a private environment for our resident and to be cognizant of noise. Smells in communal bed spaces are managed through regular toileting and ventilation at key times to reduce impact on others.

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 11(2)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	10/12/2021
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in	Substantially Compliant	Yellow	31/12/2021

	particular, that a resident uses and retains control over his or her clothes.			
Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Not Compliant	Orange	31/12/2021
Regulation 13(1)(c)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the family and friends of the resident concerned are, with the resident's consent, informed of the resident's condition, and permitted to be with the resident and suitable facilities are provided for such persons.	Substantially Compliant	Yellow	10/12/2021
Regulation 13(1)(d)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that where the resident	Substantially Compliant	Yellow	10/12/2021

	indicates a preference as to his or her location (for example a preference to return home or for a private room), such preference shall be facilitated in so far as is reasonably practicable.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/03/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/12/2022
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/12/2021
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	31/01/2022

Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	28/02/2022
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	31/03/2022
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	31/12/2021
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by	Not Compliant	Orange	31/01/2022

	staff.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	10/12/2021
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 practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/12/2021
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	10/12/2021
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.	Substantially Compliant	Yellow	24/12/2021
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1)	Substantially Compliant	Yellow	10/12/2021

	available to staff.			
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	31/01/2022
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.	Not Compliant	Orange	31/12/2021
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	31/03/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure	Substantially Compliant	Yellow	31/01/2022

	that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	10/12/2021