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:	17 January 2023
Centre ID:	OSV-0000098
Fieldwork ID:	MON-0038589

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:	49

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 17 January 2023	10:30hrs to 17:45hrs	Claire McGinley	Lead
Tuesday 17 January 2023	10:30hrs to 17:45hrs	Fiona Cawley	Support

What residents told us and what inspectors observed

Inspectors met and spoke with several residents, and observed the interactions between residents and staff throughout the day of inspection. The overall feedback was positive, with residents informing inspectors that 'life is good', the 'food is good and I get plenty of it', 'it is the next best thing to home', and that they were happy with the care and support provided in the centre. Staff were observed to know the residents well and interact with them in a meaningful manner.

On the day of inspection, inspectors were informed that activities commenced with residents attending daily mass in the on-site church. Residents were observed relaxing and enjoying the variety of communal spaces in the centre. Some residents attended activities in the communal dayroom, while others were sitting watching television. Some residents appeared relaxed in their bedrooms listening to the radio. Activities continued throughout the day. Inspectors observed nine residents actively participating in an exercise program with staff on the morning of inspection, and observed residents joining in a sing-along in the afternoon.

Inspectors observed the dining experience for residents. Staff were available to assist the residents with their meals, and assistance provided was dignified and respectful, with staff sitting and interacting with the residents. Throughout the day, inspectors observed residents being offered drinks and snacks, by staff who knew the residents well.

Inspectors observed that the centre was bright, spacious, and laid out to meet the needs of the residents. The centre provided accommodation for residents on the ground floor in mainly single room accommodation. Residents had adequate storage space, to store their clothes and personal belongings. Residents rooms were bright and airy, and some rooms were personalised with photographs and personal furniture. Residents informed inspectors that 'they liked their room' and that they 'had a great view from their room'. Residents were observed moving around the centre freely. Residents requiring assistance or supervision were provided with timely assistance and the interactions were noted to be person centred, kind and patient. Residents could independently access a secure, well-maintained outside garden.

Generally, the premises was observed to be clean and tidy. The premises was observed to be in a fair state of repair. Maintenance issues were identified by staff and fixed as needed. Storage within the centre was generally well organised. However, one storage area was observed to contain a mixture of clinical and non-clinical items, for example, resident equipment, nutritional supplements and medication trolleys.

Inspectors observed that a number of fire doors did not close completely when released and others had large gaps between the door and the floor or in the centre where the doors met. This meant that these doors would not be effective in

containing smoke in the event of an emergency.

Inspectors reviewed the laundry process and observed that arrangements were in place to minimise the risk of residents personal clothing becoming lost. The laundry was observed to be visible clean. The staff in the laundry were knowledgeable about their role, and the flow of laundry ensured that there was no cross contamination between clean and dirty laundry. However, inspectors observed some holes on the laundry flooring which were not amenable to cleaning.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

This was an unnanounced risk inspection carried out by inspectors of social services to;

- assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended).
- follow up on actions taken by the provider to address issues of substantial compliance found on the last inspection in September 2021.
- follow up on notifications and information submitted by the provider and person in charge.

The findings of this inspection were that, while the inspectors found evidence that residents received good quality care, the lack of staffing resources impacted on the management systems in place to ensure a safe, consistent and quality service was provided to residents living in the centre. Inspectors were not assured that the quality and the safety of the service could be consistently met as continued non-compliance was identified with Regulation 16: Training and staff development, Regulation 23: Governance and management, Regulation 21: Records, and Regulation 5: Individual assessment and care plan. Furthermore, action was required in relation to the management of fire safety, risk management, and the maintenance of the premises.

The registered provider was the Order of St. Camillus. The registered provider had a clear management structure in place that identified the lines of authority within the centre. The person in charge was supported by an assistant director of nursing, a team of nurses, care partners, cleaning, catering, activities, administration and maintenance staff.

A number of management systems were implemented within the service since the last inspection. An auditing system was introduced in October 2022 to monitor, evaluate and improve the quality of the service provided to residents. A range of clinical and environmental audits were completed including medication

management, resident rights, infection prevention and control and waste management. A monthly quality improvement meeting was commenced in November 2022 where the results of the audits and actions needed to improve the quality of the service were discussed. Communication systems within the centre were also improved with the implementation of these monthly quality improvement meetings, where all accidents and incidents, medication errors, care plans, resident feedback , health and safety, clinical governance, external reports and staff issues were also discussed within the management team. Records of meetings with staff within the centre had been standardised and were in the process of being implemented at the time of inspection.

Staffing levels on the day of inspection were adequate to meet the care needs of the current 49 residents. However, the position of the clinical nurse manager, three staff nurses and five care partners remained vacant. Inspectors were informed that the provider had taken the decision to cease admissions until staffing had stabilised. A recruitment programme was in place. However, rosters reviewed found the person in charge and the assistant director of nursing were regularly allocated to provide direct provision of nursing care to the residents. This meant that there was less time available for the supervision of staff, and the monitoring and oversight of the service. This was evidenced by inadequate oversight of the risk management sytems and the nursing documentation systems. Record-keeping, including the management of policies, was also not in line with regulatory requirements

The person in charge was responsible for the oversight of the risk management system, including maintaining a risk register to record all potential risks to the safety and welfare of residents and the controls in place to reduce the risk of harm to residents. Inspectors found that there was a risk management policy in place. However, inspectors found that the risk register had not been appropriately reviewed and updated since September 2021. The measures and actions in place to control the risk of abuse were not in place.

While areas of good staff practice and knowledge were found, staff training records reviewed found that staff did not have access to up-to-date education and training appropriate to their role, as training had not been scheduled within the centre throughout 2022. A review of the training record found that staff did not have access to up-to-date fire training, manual handling training and nurses did not have up-to date medication management training. Inspectors acknowledged that manual handing and fire training were scheduled for the end of January 2023.

The record management systems were not robust. The inspectors reviewed a sample of staff personnel files and found gaps in the information required to be maintained as detailed under Schedule 2 of the regulations. Garda vetting was not in place in three staff records reviewed. Induction of new staff was not consistently recorded for staff who commenced in employment since the previous inspection. Resident records were not kept in a secure manner as they were openly accessible at a nurse's station and in a mixed storage area accessible to all staff.

Information regarding the complaints process was displayed in the foyer and at nurse's stations within the centre. Inspectors reviewed a number of closed

complaints. Complaints reviewed were adequately recorded, in line with the requirements of regulation 34. Residents were aware of who to speak to, should they have a complaint.

Regulation 15: Staffing

On the day of inspection, there was sufficient staff to meet the assessed needs of the 49 residents living in the centre, and for the size and layout of the building.

Judgment: Compliant

Regulation 16: Training and staff development

Staff in the centre did not have access to up-to-date training appropriate to their role. For example, fire safety update, manual-handling, and medication management training were all found to be out of date.

As a result of the nursing management team being reallocated to nursing duties from management and oversight duties, staff were not appropriately supervised. This was evidenced by;

- inadequate oversight of nursing documentation
- poorly documented staff induction

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was maintained within the centre, and included the information specified in paragraph (3) of Schedule 3.

Judgment: Compliant

Regulation 21: Records

The recruitment, selection and Garda vetting policy was not updated in line with regulatory requirements, at intervals not exceeding three years. Staff records reviewed did not contain the documents set out in Schedule 2 of the regulations, for

example;

- A National Vetting Bureau disclosure was not in place for three staff members.
- There was no evidence of relevant qualifications in three staff records.
- Evidence of current nursing/ professional registration was not provided in the records of two registered nurses.
- A full employment history was not consistently recorded.
- Records of induction of new staff were not available.

Resident records were not kept in a safe manner. For example, resident medication records were accessible to all staff in a storage area, and resident care records were openly accessible at a nurses station.

Judgment: Not compliant

Regulation 23: Governance and management

The provider did not ensure there was sufficient resources in place to ensure the safe and consistent delivery of care. While the provider was actively recruiting, the position of the clinical nurse manager, three staff nurses and five care partners remain vacant. These vacancies were being filled by the nurse management team. A review of the roster found that the person in charge and the assistant director of nursing were on duty as the nurse delivering care to the residents, on eight out of the last 14 days. The lack of consistent supervisory hours had an impact on the oversight of a number of key areas including, resident assessment and care planning, fire precautions and records management.

The systems in place to provide effective oversight of the management systems required action to ensure full compliance with the regulations. For example, the risk management systems and the nursing documentation systems.

The centre's own quality assurance systems, such as the auditing system, had not identified a number of areas of risk. For example, a staff records audit did not identify the risk of absence of Garda Vetting in staff records. The registered provider had failed to regularly review and update known risks, such as the reduced staffing resources within the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Complaints reviewed were managed in line with the requirements under Regulation

34.

Judgment: Compliant

Quality and safety

The inspectors found that the interactions between residents and staff was kind and respectful throughout the inspection. Overall inspectors found that a satisfactory standard of care was provided to residents in St Camillus Nursing Centre. Inspectors spoke with 10 residents who informed the inspectors that they were 'well looked after', and that 'staff were very obliging and very good'. While residents described a satisfactory quality of life in the centre, a review of the quality and safety of the service found that action was required in relation to the management of fire safety, which posed a risk to the safety of the residents. Further action was also required with, risk management, individual assessment and care planning, and the maintenance and upkeep of the premises to ensure compliance with regulation.

Inspectors reviewed a sample of seven resident's assessments and care plan records. There was evidence that the residents' needs were assessed prior to admission. A range of validated assessments were carried out following admission including nutrition, dependency, skin integrity, falls, and manual handling. The majority of care plans were up-to-date and contained person-centred information with sufficient detail to guide care. However, not all care plans reflected the resident's current health care needs. For example, a change in the residents condition was not updated to reflect the care required. Further findings are discussed under Regulation 5: Individual assessment and care plan.

Generally, the premises was observed to be clean and tidy. Resident equipment was observed to be clean. Cleaning staff spoken to were knowledgeable about the cleaning processes used within the centre and informed inspectors of new cleaning equipment and processes that they were awaiting training on prior to its implementation.

The premises was observed to be in a fair state of repair. However, inspectors observed some residents rooms with chipped paint, items of resident furniture that were scuffed, and some holes in flooring along corridors.

A review of fire precautions evidenced that arrangements were in place for the testing and maintenance of the fire alarm system, emergency lighting and fire-fighting equipment. Staff spoken with demonstrated appropriate knowledge of the centres' fire precautions and evacuation procedures. However, inspectors found that fire safety fittings, such as fire doors, were not maintained in a way that would ensure the containment of a fire. In addition, arrangements for the safe evacuation of residents, such as personal emergency evacuation plans and floor plans were inaccurate. The provider failed to provide assurance that resident's could be

evacuated from the centre in a timely manner in the event of an emergency.

Residents were provided with appropriate access to medical and healthcare services. A system of referral was in place for residents to access the expertise of allied health and social care professionals such as dietetic services, speech and language, physiotherapy, and occupational therapy.

The provider had systems in place to monitor restrictive practices. Inspectors found that appropriate risk assessments and care plans were in place for this restrictive practice.

Residents confirmed that friends and families were facilitated to visit, and inspectors observed visitors coming and going throughout the day. Visitors spoken with confirmed that they were happy with the standard of care provided within the centre.

Inspectors observed that residents were free to exercise choice about how to spend their day and attend activities that were of interest to them. Residents were provided with access to daily newspapers, radio, and television. Regular resident's meetings were held and a range of topics were discussed including; housekeeping, nursing care, activities, laundry and food. Action plans were in place for resident issues raised at these meetings.

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted, in line with the requirement of Regulation 11.

Judgment: Compliant

Regulation 17: Premises

Areas of the premises were not maintained in a satisfactory state of repair as required by Schedule 6 of the regulations. For example; inspectors observed chipped paint, items of furniture that was scuffed, some holes in flooring along corridors and in the laundry.

Judgment: Substantially compliant

Regulation 26: Risk management

Risk management Policy did not meet the requirements set out under regulation 26(1). For example, the measures and actions in place to control the risk of abuse was not in place.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Some action was required by the registered provider to comply with fire precautions in the centre. This was evidenced by;

- Some fire doors in the premises contained visible gaps when closed while some doors were misaligned and did not close correctly when released. This compromised the function of the fire doors to contain smoke in the event of a fire emergency.
- Fire plans on display were not up-to-date and did not reflect all rooms within the centre. This could cause confusion and a delay to the safe evacuation of the centre, in the event of an emergency.

The provider failed to provide assurance that residents could be safely evacuated. This is evidenced by;

- Resident personal emergency evacuation plans were not up-to-date and therefore may not reflect the essential details for the safe evacuation of the resident.
- Fire evacuation drills, completed to ensure the safe and timely evacuation of residents in the event of a fire emergency, were not completed since 28 September 2021.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Individual assessment and care planning documentation was available for each resident in the centre. However, not all care plans reflected the resident's current health care needs. For example, a resident assessed as being at a high risk of developing pressure related injury did not have a care plan in place to direct care.

A number of care plans were not reviewed at intervals not exceeding four months in line with the regulations. For example, a resident who was receiving ongoing treatment for a wound did not have their assessment or care plan updated to reflect progress or deterioration of the wound.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with timely access to health and social care professional services. Inspectors found evidence that recommendations received were followed resulting in positive resident outcomes.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The provider had systems in place to monitor environmental restrictive practices to ensure that they were appropriate. Residents that required the use of bed rails had an appropriate assessment of risk and supporting documentation in place.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had opportunities to participate in activities in accordance with their interests and capacities. Residents had access to radio, television, newspapers and other media.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Camillus Nursing Centre OSV-0000098

Inspection ID: MON-0038589

Date of inspection: 17/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Fire Training (including Evacuation) through an outside agency, for all staff was completed 10/03/23. Safeguarding training has commenced and is ongoing for all staff and staff are being registered each day. All nurses have completed the course. Medication Management Training for all nurses was completed on 28/02/23. Syringe Driver Training for nurses has been arranged on-site for 20th & 27th April. Arrangements have been made with an outside organization to provide Manual Handling / Resident Moving Training. They have to provide us with date for this training. Five new care staff have commenced and a full day's induction was held and supporting documentation was completed; they are assigned a mentor daily. This format of induction is now in place for all new staff. An evaluation will take place one month after commencing duties. The P.I.C. is no longer rostered as a nurse. The A.D.O.N. is no longer rostered as a nurse, unless exceptional, unforeseen, circumstances occur.	
Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
National Vetting Bureau Disclosure is in place for all staff.

Evidence of current N.M.B.I. registration and qualifications is in place for all nursing staff.

A full employment history is now in place for all staff members.

Records of induction for new staff are now in place.

Residents drug charts have been moved to a secure room. New lockable storage for all residents' records will be completed by 31/03/23.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The P.I.C. is no longer rostered as a nurse, giving him the time needed for Governance. The A.D.O.N. is also no longer rostered as a nurse, unless in exceptional, unforeseen circumstances.

Five Care Partners positions are now filled, with overseas staff in place.

Three Staff Nurses positions are now filled, with overseas staff in place. Two further nurses have also been recruited in anticipation of staff retirement. One nurse will take up her post on 14/03/23, the second in May 2023.

The CNM position is yet to be filled, we have approached a nurse and offered her the position and are awaiting her reply.

The Risk Register has been updated and divided into sections – Clinical; Residents; Staff; Environmental; Church; IPC; Catering. It now includes: Medication Errors; Responsive Behaviour; IPC; Restraint; Falls; Fire; Self harm, Unexpected Absence of a Resident.

A System is now in place to ensure the Management Team knows when Resident-Specific Nursing Documentation is due for updating, such as Care Plans. The Management Team will then ensure that the nurses update their allocated Care Plans & Nursing Records.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A comprehensive inventory of required repairs and replacements has been made, and Maintenance Planner has been put in place to prioritize and schedule work.
A daily reporting system is in place for the reporting of items which need repair or replacement, the Maintenance Man checks this. It is graded depending on the urgency of the repair (Major / Moderate / Minor) in relation to resident / staff / visitor safety and requirements.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
The Risk Register has been updated and divided into sections – Clinical; Residents; Staff; Environmental; Church; IPC; Catering. It now includes: Medication Errors; Responsive Behaviour; IPC (including all aspects of Infection control); Restraint; Accidental Injury; Fire; Self harm & Unexpected Absence of a Resident.

The Risk register now contains a specific Risk Assessment in regard to Safeguarding.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Training (including Evacuation) through an outside agency, for all staff was completed 10/03/23.

A full one-day audit of all Fire Doors throughout the building was completed on 02/03/23. They have compiled a report of all doors and emergency exits requiring remedial works. They will use the traffic light system to prioritize the most urgent work. Following on from this will continue to conduct a six-monthly fire safety audit of the premises.

The Fire Escape-Route Plans on display have been amended by the architect to accurately demonstrate the usage of every room in the building.

All Residents' P.E.E.P.S. have been updated and are in place in the residents' bedrooms detailing their means of evacuation and date of assessment.

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: We now have a system in place to alert the Management Team when routine updating of the residents Care Plans is required, the Management Team will advise the nurses responsible that they must update their assigned Care plans.	

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	13/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	13/02/2023
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	13/03/2023
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	Not Compliant	Orange	13/03/2023

	Inspector.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	31/03/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	13/03/2023
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.	Substantially Compliant	Yellow	30/05/2023
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	13/03/2023
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and	Not Compliant	Orange	02/03/2023

	building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	02/03/2023
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	10/03/2023
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	Substantially Compliant	Yellow	10/03/2023

	procedure to be followed in the case of fire.			
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	13/03/2023
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	13/03/2023
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	13/03/2023