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:	Announced
Date of inspection:	20 September 2023
Centre ID:	OSV-0000098
Fieldwork ID:	MON-0031831

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:	52

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
Wednesday 20 September 2023	08:45hrs to 18:00hrs	Sean Ryan	Lead
Wednesday 20 September 2023	08:45hrs to 18:00hrs	Sarah Quilter-Lee	Support

What residents told us and what inspectors observed

Residents living in St. Camillus Nursing Centre were complimentary of the quality of care they received from staff who they described as patient, caring, and kind. Residents told the inspectors that the staff and management valued their feedback and made them feel included in the decisions made about how the service is run, and how the quality of the service could be improved. Residents told the inspectors that staff were attentive to their needs and made them feel safe living in the centre.

The inspectors were met by the person in charge, provider representative, assistant director of nursing, and administrator on arrival at the centre. Following an introductory meeting, inspectors walked through the centre and met with residents and staff. Inspectors spoke with seven residents in detail about their experience of living in the centre.

There was a calm, friendly and relaxed atmosphere in the centre throughout the inspection. During the morning, staff were observed to attend to residents requests for assistance promptly. Staff were observed to provide care to residents in an unhurried manner and engage with residents socially. Residents who spoke with the inspectors were complimentary in their feedback about the staff. Residents described how staff never made them feel rushed, and they reported that they were always greeted with 'respect, kindness, and friendliness'. Residents told the inspector that they enjoyed engaging with all staff, and that they spent time chatting with them throughout the day. Some residents described themselves as 'lucky to live here' referring to their centre as their home. One resident told the inspector about their experience of coming to live in the centre. While the resident expressed that they missed their own home, moving to the nursing home was 'the best decision' they made because they needed 'company and friendship'. The resident told the inspectors how staff supported them to adjust to living in the centre and form friendships with other residents.

The premises was appropriately decorated, well-lit, clean, and warm for residents. There were appropriately placed hand rails to support residents to walk independently around the centre. There was a large enclosed garden accessible to residents. The garden area was appropriately furnished and maintained to a satisfactory standard. There was ample storage facilities for equipment, and corridors were maintained clear of items that could obstruct residents who were observed walking around the centre throughout the day. Inspectors observed that some shared bedrooms were small in size. The layout and configuration of four shared bedrooms would not support the mobility care needs of some residents who require specialised seating, or a hoist for transfer. In recognition of this, the provider ensured that those bedrooms were occupied by residents with lower dependency care needs. Furnishings in communal areas and bedrooms were observed to be well maintained, and comfortable for residents. Inspectors observed that some bedrooms, storage area, and corridors were not appropriately maintained. Paint on walls and skirting was visibly chipped, doors were visibly damaged, and floor

coverings were damaged and uneven.

The provider had progressed to carry out remedial works on fire doors. Inspectors observed that some fire doors had been repaired to ensure their effectiveness in the event of a fire emergency. Works were in progress during the inspection to complete outstanding repairs to the fire doors. There were some areas of the premises, such as storage area, where holes in the ceiling had the potential to compromise fire containment measures in the centre. Fire-fighting equipment was observed to be overdue its annual inspection. The person in charge confirmed that the annual inspection of the fire-fighting equipment was scheduled for the week following this inspection.

Residents told the inspectors that they were satisfied with their bedroom accommodation, furnishings and storage facilities for their personal belongings. Bedrooms were personalised, and decorated according to each resident's individual preference. Residents were encouraged to personalise their bedrooms with items of significance, such as ornaments and photographs.

Resident's personal clothing was laundered on-site. Residents expressed their satisfaction with the service provided, and described how staff took care with their personal clothing and returned it promptly to their bedroom. Arrangements were in place to minimise the risk of residents personal clothing becoming lost or misplaced.

Residents were complimentary of the dining experience and the quality of the food they received. The dining experience was observed to be a social and enjoyable experience for residents. Staff were available to provide discrete assistance and support to residents if required. Food was freshly prepared and met residents individual nutritional requirements. Residents confirmed the availability of snacks and refreshments outside of scheduled meal times.

Residents told the inspectors that staff supported them every day to maintain their individual style and appearance. This included assisting residents to select their clothing, apply make-up, and clean their jewellery. All residents were observed to be dressed and groomed in line with their personal preference and style.

Throughout the day, the inspector observed that residents were actively engaged in a variety of meaningful activities. There was a detailed activity schedule developed in consultation with the residents. Residents were observed enjoying music and engaged in games and other activities during the morning. Staff were observed to engage in activities with residents and this added to the social experience of the activities. In the afternoon, residents attended a live music event.

Residents confirmed that they had opportunities to meet with the management team to discuss their views on the quality of the service.

The following sections of this report detail the findings with regard to the capacity and capability of the centre and how this supports the quality and safety of the service provided to residents.

Capacity and capability

This was an announced inspection to monitor the designated centre's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended. The provider had applied to renew the registration of the centre, and this application was reviewed on this inspection. Inspectors also followed up on a compliance plan submitted by the provider following the last inspection of the centre in January 2023.

The findings of this inspection were that the provider had taken action to ensure there was an effective management structure in the centre, in line with the statement of purpose. Further action had been taken to ensure the service was adequately resources in terms of staffing, and the provider had implemented some management systems to ensure there was effective oversight of the quality of care provided to residents. However, inspectors found that some of the management systems required further action to ensure that a safe, consistent and quality service was provided to residents living in the centre through appropriate oversight of risk management, record management, and resident's finances. This also included the systems in place to evaluate and improve the quality of the service. Action was also required to ensure full compliance with Regulation 28, Fire precautions.

The Order of St. Camillus is the registered provider of this centre. 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, and a clinical nurse manager.

The centre maintained the staffing resources in line with the statement of purpose and this was monitored in line with the resident's assessed dependency level and care needs. There was a registered nurse on duty at all times, supported by a team of health care staff. Since the last inspection, a clinical nurse manager had been recruited and this additional resource was found to have a positive impact on the supervision of the care provided to residents.

The centre had established management systems in place to monitor the quality and safety of the service provided to residents. Key aspects of the quality of resident care were collected and reviewed by the person in charge and included information on falls, weight loss, nutrition, complaints, and other significant events. There was a schedule of monthly audits that were completed by the clinical management team. This included audits of the quality of environmental hygiene, restrictive practices, clinical documentation, and fall's management. However, a review of completed audits found that some audits were not effectively used to identify risks and deficits in the service. For example, audits of staff personnel files assessed compliance with the documents to be held for each member of staff as required by the regulations. This audit failed to identify incomplete staff files and therefore, no corrective action could be taken.

Risk management systems were guided by the risk management policy. This policy

had been updated, and detailed the systems that were in place to identify, monitor and respond to risks in the centre that may impact on the safety and welfare of residents. A review of the risk register evidenced that some clinical and environmental risks were assessed and had been categorised according to their level of risk to residents. However, the risk register did not contain some of the known risks in the centre, such as risks identified with the impaired integrity of fire doors. The exclusion of known risks from the centre's active risk register impacted on the centre's ability to minimise and appropriately manage risk. The effectiveness of the controls in place to mitigate risks to residents were not subject to review. For example, some risks specific to infection prevention and control management had not been reviewed since 2021. There were systems in place to identify, document and learn from incidents involving residents.

Notifiable incidents, as detailed under Schedule 4 of the regulations, were notified to the Chief Inspector of Social Services within the required time-frame.

Record keeping and file management systems consisted of a paper-based systems. A review of staffing records found that all staff personnel files contained a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021. However, not all files contained the information specified in Schedule 2 of the regulations. For example, some staff files did not contain two written references or a full employment history. Additionally, some records specific to the care and treatment provided to residents could not be retrieved. Additionally, the records of all monies or valuables deposited by a residents for safekeeping were not maintained in line with the requirements of the regulations.

There was a comprehensive training and development programme in place for all grades of staff. Staff demonstrated an appropriate awareness of their training with regard to fire safety procedures, and their role and responsibility in recognising and responding to allegations of abuse. There were systems in place to induct, orientate, support and supervise staff through senior management presence.

Registration Regulation 4: Application for registration or renewal of registration

The application for registration renewal was made and the fee was paid.

Judgment: Compliant

Regulation 15: Staffing

The staffing levels and skill-mix were appropriate to meet the assessed needs of residents, in line with the statement of purpose. There was sufficient nursing staff on duty at all times, and they were supported by a team of health care and activities staff. The staffing complement also included catering, laundry, administrative and

management staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were facilitated and supported to attend training relevant to their role.

Staff were appropriately supervised to carry out their duties to protect and promote the care and welfare of all residents. Arrangements were in place to induct and orientate staff, and to support staff to provided safe and effective care to residents.

Judgment: Compliant

Regulation 21: Records

The management of records was not in line with regulatory requirements. For example;

- Staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, one staff file did not contain two written references, a staff file did not contain a full employment history, and a staff file did not contain a relevant professional qualification.
- Records required by Schedule 3 of the regulations were not kept in a manner that was accessible. For example, some records of a person's health, condition, and treatment given on a daily basis could not be retrieved. This included records with regard to the management of a wound, and nutritional monitoring records.
- Records of monies deposited by residents for safekeeping were poorly maintained. For example, records of transactions, and the date on which money and valuables were received was not consistently recorded ,as required by Schedule 3 of the regulations.

Judgment: Not compliant

Regulation 22: Insurance

The provider had an up-to-date contract of insurance in place against injury to residents, and loss or damage to residents' property.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place to monitor the quality of the service were not fully effective to ensure the service provided to residents to residents was safe and effectively monitored. For example:

- Risk management systems were not effectively implemented. The centre's risk register did not contain known risks in the centre such as the risks associated with the impaired integrity of fire doors awaiting remedial action.
- The systems in place to manage resident's finances was not robust. For example, where resident had handed in monies for safekeeping in the safe, the records or transactions were not appropriately maintained. This was indicative of a lack of a clear policy, procedure and process to underpin a safe and effective management system.
- The auditing system used to evaluate and improve the quality and safety of the service was not effective. For example, audits of clinical care records, staff personnel records, and nutritional care records were not effective to identify aspects of the service that required quality improvement.
- There was poor oversight of record-management systems to ensure compliance with the regulations.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents were appropriately notified to the Chief Inspector of Social Services within the required time frame.

Judgment: Compliant

Quality and safety

Residents living in this centre received a good standard of care and support which ensured that they were safe and that they could enjoy a good quality of life. There was a person-centred approach to care, and residents' well-being and independence were promoted. While the provider had taken action to improve the quality of residents individual assessments and care plans and the needs of residents were known to the staff, the actions taken were not sufficient to ensure residents care

plans accurately reflected the assessed needs of the residents, and provide guidance on the care to be provided to residents. Additionally, further action was required to ensure the premises was maintained in a satisfactory state of repair for residents, and that residents were protected from the risk of fire.

A sample of resident's assessments and care plans were reviewed, and evidenced that the residents' health and social care needs were being assessed using validated tools. Care plans were reviewed in consultation with residents and, where appropriate, their relatives, at intervals not exceeding four months. While all residents had a care plan, and there was evidence that resident's needs had been assessed using validated assessment tools, the assessment findings were not always reflective of the residents actual care needs. Consequently, the care plans did not identify the current care needs of the residents or reflect the person-centred guidance on the current care needs of the residents.

A review of residents' records found that there was regular communication with residents' general practitioner(GP) regarding their health care needs and residents were provided with access to their GP, as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further expert assessment and treatment. This included access to the services of speech and language therapy, dietetics, occupational therapy, physiotherapy, and tissue viability nursing expertise.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of their safeguarding training and detailed their responsibility in recognising and responding to allegations of abuse.

A review of fire precautions found that arrangements were in place for the testing and maintenance of the fire alarm system, emergency lighting, and fire-fighting equipment. The provider had sought expertise from an external fire consultant in 2023 and the findings highlighted that the integrity of some fire doors were compromised. Remedial works were ongoing to address the findings of the assessment report. Further action had been taken to ensure that fire escape plans reflected the layout of the centre, and resident's personal emergency evacuation plans accurately detailed the residents assessed evacuation needs. Nonetheless, further action was required to ensure full compliance with the regulations. For example, while staff demonstrated an awareness of the actions in place to mitigate the risk fire to residents, some staff did not demonstrate an appropriate awareness of the centres fire safety policy and evacuation procedures. Further findings are discussed under Regulation 28: Fire precautions.

Action had been taken with regard to the maintenance of the premises since the previous inspection. There was a programme in place to replace damaged items of furniture, and some areas of the premises had been redecorated. Nonetheless, there were aspects of the premises that required action to ensure it was maintained in a satisfactory state of repair. This included floor coverings, and some wall and doors that were visibly damaged.

Residents told the inspector that they felt at home in the centre and that their privacy and dignity was protected. Inspectors observed several positive interactions between staff and residents throughout the inspection. Interactions were polite, supportive and respectful.

Residents rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Arrangements were in place for residents to meet with the management to provide feedback on the quality of the service they received. There were opportunities for residents to participate in meaningful social engagement and activities through one-to-one and small group activities in each of the three communal rooms. Residents could choose what activity they wanted to attend or could choose to remain in their bedroom and watch television or chat with staff. Residents could attend daily religious services in the centre's chapel, or view the religious service in their bedroom through a video link.

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Those arrangements were found not to be restrictive, and there was adequate private space for residents to meet their visitors.

Judgment: Compliant

Regulation 17: Premises

Action was required by the registered provider to comply with Regulation 17, premises. This was evidenced by;

- Doors, frames and skirting were visibly damaged in some areas of the building that included resident's bedrooms.
- Walls were damaged and paint was chipped in some resident's bedrooms.
- Floor coverings were damaged in some store rooms and floors were lifting and uneven in some parts.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the provider in order to comply with the requirements of

Regulation 28: Fire precautions.

Arrangements for containing fire in the designated centre required further action. This was evidenced by;

- There were holes around services, pipes and electrical cables that had not been appropriately sealed to prevent the spread of smoke and fire. This included areas such as store rooms, and linen rooms.

The provider had not ensured that all staff working in the centre were aware of the procedure to be followed in the case of a fire, through fire drills carried out at suitable intervals. For example, a fire evacuation drill had not been completed since January 2023. Consequently, a number of staff had not participated in a fire drill, and demonstrated poor awareness of the procedure to implement in the event of a fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

A review of a sample of resident's assessment and care plans found that they were not in line with the requirements of the regulations.

- Resident's care plans did not accurately reflect the assessed needs of the residents. For example, residents assessed as being at risk of falls, and at risk of impaired skin integrity did not have a corresponding care plan developed. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated when a resident's condition changed. For example, residents who had experienced weight loss did not have their care plan updated to reflect their current care needs, risk of malnutrition, or weight management plan.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre as required or requested. Services such as physiotherapy were available to residents weekly and services such as tissue viability nursing expertise, speech and language and dietetics were available through a system of referral.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse. Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre. The provider did not act as a pension agent for any residents living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Staff demonstrated an understanding of residents' rights and supported residents to exercise their rights and choice, and the ethos of care was person-centred. Residents' choice was respected and facilitated in the centre. Residents could retire to bed and get up when they choose.

There were facilities for residents to participate in a variety of activities such as art and crafts, bingo, exercise classes, and live music events. Residents complimented the provision of activities in the centre and the social aspect of the activities on offer.

Residents attended regular meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received.

Residents were provided with information about the services they could access, if needed. This included independent advocacy services.

A variety of daily national and local newspapers were available to residents. Religious services were facilitated regularly.

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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for St Camillus Nursing Centre OSV-0000098

Inspection ID: MON-0031831

Date of inspection: 20/09/2023

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 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: A new Staff File Audit Tool is in place to ensure that staff files are maintained in accordance with the Regulations and the Administrator is aware of her responsibility to maintain files in accordance with the Regulations. Up to date NMBI certificates were heretofore kept in a separate folder, these have now been moved into the individual staff nurse's file. The residents daily narrative notes and daily Wound Care Charts, where appropriate, will now remain in the individual resident's section of the Care Plan folders, resident notes are now accessible at all times. In relation to resident monies & small valuables deposited for safekeeping with the administrator; a robust accounting system is now in place, which includes photographs of valued items such as rings. A bound book is in place, detailing the transactions. A monthly check, on the last Friday of each month, will be performed and double signed by the Adm and PIC/APIC to ensure that the records are up-to-date. The policy has been updated to reflect a more robust maintenance of records. The newly recruited CNM is now in place. One of her roles is to ensure that resident assessment records and care plans have been updated. Care Plans will be updated at regular intervals, not greater than four-month and all nurses are reminded and aware to update care plans following events in the lives of the residents, such as falls or other incidents. An Assessment Schedule is in place to direct the CNM and Staff Nurses in regard to updating.	
Regulation 23: Governance and	Substantially Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
We will ensure that the quality and safety of care delivered to residents is monitored on an ongoing basis.

Risk Management. The Risk Register is now kept in the Clinical Room, to which all staff have access. Risk assessments relating to individual Staff members have been removed and placed in their staff files. Risk assessments relating to areas no longer currently considered a risk have been removed, such as COVID-19 restrictions. It includes current risks such as impaired integrity of the Fire Doors and staff fire training.

In relation to resident monies deposited for safekeeping with the administrator, a robust accounting system is now in place, which includes photographs of valued items kept in safekeeping, such as rings. A bound book is in place, detailing the transactions. A monthly check, on the last Friday of each month, will be performed and double signed by the Adm and PIC/APIC to ensure that the records are up-to-date. The policy has been updated to reflect a more robust maintenance of records.

We organised the representative of the company supplying our Quality Management System to visit us on Thursday 12th October to give us further education in the correct use of the audit tools, to ensure that they give the most robust, reliable data, from which we can correct areas found to be in need of improvement.

A new Staff File Audit Tool is in place to ensure that staff files are maintained in accordance with the Regulations and the Administrator is aware of her responsibility to maintain files in accordance with the Regulations. Up to date NMBI certificates were heretofore kept in a separate folder, these have now been moved into the individual staff nurse's file.

The newly recruited CNM is now in place. One of her roles is to ensure that resident assessment records and care plans have been updated. Care Plans will be updated at regular intervals, not greater than four-month intervals and all nurses are reminded and aware to update care plans following events in the lives of the residents, such as falls or other incidents. An Assessment Schedule is in place to direct the CNM and Staff Nurses in regard to what and what needs updating.

The residents daily narrative notes, daily Wound Care Charts etc. will now remain in the individual resident's section of the Care Plan folders, resident notes are now accessible at all times.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A further full environment check has been completed and the areas of wear & tear identified have been added to the Maintenance Planner.

We are looking at permanent solutions for areas of high traffic, such as covering the lower door-frames with protectors and the lower sections of doors with protective panels.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A Fire Training Schedule is now in place.

The Management Team are now assured that all staff are aware of the procedures to be followed in the event of discovering / suspecting a fire. Documented Fire Training has taken place on seven occasions since 21st September 2023 in order to ensure staff are familiar with the procedure to be followed. The sessions included Ski-Sheet & Bed evacuations to ensure that all staff are aware of the procedures to follow. The training covered the following topics: Use of fire extinguishers (actually letting off both Foam and C02). The role of Fire wardens; How to sound the alarm; Calling for help; the procedure to follow when the fire alarm is sounded. How to call the fire brigade; The role of the person-in-charge; PEEPS. Progressive Horizontal Evacuation. Managing a person who is on fire. Known risks – residents who smoke.

We have been in contact with a fire consultancy company to perform a full fire compliance assessment of the building. From this we will plan remedial work, based on their report.

The Fire company have now completed the Red & Orange phases of the traffic-light plan. All fire doors are now certified as being fully compliant.

We have spoken with an engineer from our fire company in regard to the gaps around pipes and wires. He has visited (12th October 2023) and has identified where sealing is necessary and will recommend a method of sealing.

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:

There is an Assessment Schedule in place to ensure that all care plans are routinely updated, at intervals not greater than four months. Staff Nurses are aware to update care plans every time there is a change in a residents' condition or an incident occurs, such as a fall, deterioration in skin integrity or weight loss. The new CNM has responsibility to oversee the process and ensure it is kept up to date.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/02/2024
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	31/10/2023
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Substantially Compliant	Yellow	13/10/2023
Regulation 23(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	13/10/2023

	systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
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	13/10/2023
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	Substantially Compliant	Yellow	13/10/2023

	aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/12/2023
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	13/10/2023
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	13/10/2023