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:	Aperee Living Galway
Name of provider:	Aperee Living Galway Limited
Address of centre:	Ballinfoyle, Headford Road, Galway
Type of inspection:	Unannounced
Date of inspection:	29 November 2023
Centre ID:	OSV-0000331
Fieldwork ID:	MON-0042039

About the designated centre

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

Aperee Living Galway is a purpose built facility located on the Headford Road, Co Galway. The centre admits and provides care for residents of varying degrees of dependency from low to maximum. The nursing home is constructed on three levels. There are four double bedrooms and 52 single bedrooms. There is adequate sitting and dining space to accommodate all residents in comfort. The second floor is dedicated to accommodate residents of high dependency. The provider employs a staff team consisting of registered nurses, care assistants, administration, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	50

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 29 November 2023	11:30hrs to 17:30hrs	Una Fitzgerald	Lead
Wednesday 29 November 2023	11:30hrs to 17:30hrs	Catherine Sweeney	Support

What residents told us and what inspectors observed

Overall, the feedback from residents was that this was a nice place to live. The inspectors spoke with individual residents and spent periods of time observing staff and resident engagement in communal areas.

Aperee Living Galway is a designated centre for older people, registered to care for 60 residents. There were 50 residents living in the centre on the day of inspection.

Following an introduction meeting, inspectors walked the premises and spent time chatting with residents and speaking with staff and visitors. The centre was spread out across three floors. Each floor had a variety of communal sitting and dining rooms which were observed to be occupied by residents throughout the day. The centre was clean, warm and inviting. The atmosphere in the centre was pleasant with most interactions between staff and residents observed to be kind and respectful. Residents told the inspectors that the staff were kind to them but also added that the staff were often under pressure and did not have the time to attend to all of their needs.

While the feedback from residents on the direct care received was positive, the inspectors observed that residents who required assistance were not always provided with this in a timely and appropriate manner. The interactions and engagement between staff and residents were not always person-centered and based on the resident expressed wish. Inspectors observed a number of incidents where the residents voice was not heard, or that the needs of the residents were not appropriately met. One residents told the inspectors that they could not attend an activity of their choice as there was no staff available to facilitate them to attend.

Inspectors observed a detailed activities schedule displayed at reception. However, on the day of inspection residents could not always be facilitated to attend due to the availability of staffing resources. The staff allocated to facilitating meaningful activities for the residents were not in post. This meant that the activities schedule could not be fully implemented.

Inspectors observed a group of residents having a meal in the one of the dining rooms in the centre. In the main, residents spoke positively about the choice and quality of food, and told the inspectors they could request different meals if they would like them. Residents were also happy with the laundry services.

Inspectors observed that visiting arrangements were in place and were not restricted.

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

Capacity and capability

The finding of this inspection was that the governance and management systems in place did not ensure a safe and consistent service. An unclear organisational structure, coupled with ineffective systems of oversight, resulted in repeated regulatory non-compliance across the regulations reviewed. A shortage of staffing resources also impacted on the quality of care delivered to residents. Inspectors found that the provider had failed to implement compliance plans submitted following the last inspections of the centre. Inspectors found continued significant non-compliance with regard to the management of Regulation 28: Fire precautions. As a result, an urgent compliance plan request was issued seeking assurances that appropriate action was taken to safeguard residents in the event of a fire emergency. Assurances were submitted by the provider to the Office of the Chief Inspector following this inspection, which outline the action that would be taken to mitigate the fire risks until the fire safety works could be completed.

This unannounced inspection was carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).
- follow up on the actions taken by the provider to address significant issues of non-compliance with Regulation 28: Fire precautions, identified during the previous two inspections of the centre on 16 November 2022 and 10 May 2023.
- review the detail of an application to renew the registration of the designated centre.

Aperee Living Galway Limited was the registered provider of Aperee Living Galway. On the day of inspection, inspectors found that the organisational structure of the management team was unclear. Inspectors were informed of pending changes to this structure, however, on the day of the inspection reporting and escalation procedures were not clearly identified to the inspectors. This meant that there was no clear pathway for issues of risk to be escalated to the provider. Within the centre, the management team comprised of a person in charge, an assistant director of nursing, clinical nurse managers, staff nurses, care team, housekeeping team and administration staff.

Fire safety concerns had been identified in the centres' own fire safety risk assessment dated November 2021, and during the previous two inspections of the centre. At that time, the level of risk in the centre was such that the Chief Inspector had attached a condition to the centres' registration which ceased all new admissions into the centre until the fire safety issues were addressed. The provider made a commitment that fire related works would commence on the 29 March 2023 with a completion date of 3 January 2024. On the day of inspection, the required works had not commenced and there was no confirmed start date available.

Inspectors found that previous action taken by the provider in relation to fire safety procedures, in place to mitigate the fire risks, had not been sustained. For example;

- weekly audits on the fire evacuation equipment had not been completed since June 2023,
- weekly educational session on fire safety were no longer held,
- regular review of the resident documentation in place to guide staff on individual evacuation procedures were not always updated.
- staff had very poor knowledge in relation to what actions to take in the event of the fire alarm activating.
- regular fire safety drills were not recorded. Detailed fire drills, providing assurance that all residents could be safely evacuated in a timely manner were last completed in May 2023.

While inspectors found that the person in charge and the team within the centre was committed to quality improvement to enhance and improve the daily lives of the residents, the monitoring and oversight of the service was impacted by inadequate resources and ineffective operational support.

There were insufficient nursing staff available to safely staff the centre. A review of the staff duty roster found that the person in charge and an assistant director of nursing, with responsibility for the supervision of direct care, were regularly redeployed to provide direct nursing care and so could not fulfil their monitoring and supervisory role. Inspectors found that care delivery was not adequately suervised, evidenced by the observation of inconsistent quality in the delivery of direct care. This was a repeated non-compliance.

The management of complaints was also impacted by this lack of oversight. A review of the records of complaints found that the provider had failed to ensure that documentation was completed and reviewed in line with the centre's own updated policy. Inspectors reviewed the documentation and found that the record of complaints management was incomplete. This meant that complaints were not fully acknowledged, investigated or analysed, and no quality improvement action was implemented to ensure resident safety. This impacted on the registered provider's ability to manage and avail of learning opportunities with regards to complaints.

Regulation 15: Staffing

Staffing levels were not adequate to meet the assessed health and social care needs of the residents, or for the size and layout of the centre.

- some residents were unable to attend social activities due to lack of staffing residents requiring assistance for meals were not attended to in a timely manner

- a resident accommodated on the ground floor, where one carer was allocated, required two carers to meet their needs. This resulted in the resident having to wait extended periods of time for assistance.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The supervision of staff continued to be compromised by inadequate levels of nursing staff as the nurse management were redeployed to deliver direct care. This is a repeated non-compliance.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider failed to ensure that the designated centre had sufficient resources to effectively deliver care in line with the centres' statement of purpose. While it was acknowledge that recruitment was in progress, and that incomplete rosters were supplemented by agency staff, the lack of staffing resources was found to have a negative impact on the delivery of a safe and effective service.

The roles and responsibilities of the management team were not clearly outlined and understood by all staff. This resulted in ineffective monitoring systems, poor supervision of staff and inadequate operational support to ensure all risks in the centre were addressed.

The management systems in place were not effective to ensure that the service was safe and adequately monitored.

- The risk management system was not effective. The risk register identified inadequate staffing levels as a risk to the centre in March 2023, however, minimal action had been taken to address this issue. Furthermore, risks associated with fire safety had not been addressed.
- The systems in place to manage complaints and incidents was not effective. Complaints were poorly documented and investigated. Learning form adverse events were not identified and used to improve the quality of the service.
- Care was poorly supervised as evidence by poor care practice observed while staff attended to residents needs.
- The management of fire safety was wholly inadequate and resulted in the requirement of an urgent compliance to ensure that risks associated with fire precautions in the centre were adequately addressed.

Judgment: Not compliant

Regulation 34: Complaints procedure

Inspectors reviewed the complaints documentation and found that the provider had failed to meet regulation requirements in relation to the management of complaints. For example;

- the detail of the complaints were not fully recorded.
- complaints were closed out without any evidence of investigation or actions taken as a result of the complaint.
- the satisfaction level of the complainant was not always recorded.
- opportunities for learning and quality improvement were not identified and communicated to staff

Judgment: Not compliant

Quality and safety

Overall, most resident's health care needs were delivered to a satisfactory standard of evidenced-based care. Residents received care and support from a team of staff who knew their individual needs and preferences. Residents were complimentary of the care they received and reported feeling safe and content living in the centre. However, the registered providers history of poor governance, failure to adequately resource the centre, and failure to implement effective fire management systems impacted on the safety and care standard and therefore, continued to put residents at risk; a risk that was first identified in November 2021.

As previously stated, the provider had committed to the completion of fire safety works. However, the inspectors did not observe any evidence to support the commencement of this work. Inspectors reviewed the documentation in place that evidenced fire drills were completed. While inspectors were informed that simulated fire drills were carried out frequently, the last recorded drill made available for review was dated May 2023. Inspectors were informed that, due to staffing challenges, fire drill scenarios completed in the centre were no longer recorded. Therefore, assurances could not be provided that in the event of an emergency, residents could be evacuated in a timely manner, to a place of safety, at a time when staffing levels are at their lowest. In addition, the personal emergency evacuation procedure documentation, held in resident bedrooms, was not always up to date. This document was required to guide staff on residents mobility and level of assistance required in the event of the need to evacuate. Furthermore, staff demonstrated poor knowledge in relation to the action to be taken on the sounding

of the fire alarm. This posed a significant risk to residents, staff and visitors to the centre. An urgent compliance plan was issued to the provider during the inspection.

The quality and detail of residents care records was inconsistent. A review of the residents nursing records found that residents' needs were assessed through validated assessment tools in conjunction with information gathered from the residents and, where appropriate, their relative. However, assessments were not always reviewed in line with the changing needs of residents and therefore, did not inform the development of an appropriate care plan. Assessments did not contain the detail required to inform care plans. For example, a resident displaying responsive behaviours did not have a care plan developed to detail appropriate interventions to guide staff. Furthermore, personal evacuation plans were incomplete and did not guide staff in relation to the safe evacuation of the resident to a place of safety.

A review of residents' records found that residents had timely access to a general practitioner (GP) as requested or required. Arrangements were in place for residents to access the expertise of health and social care professionals for further assessment when required. The recommendations of health and social care professionals were observed to be implemented.

The previous inspection of this centre found that the procedures in place to ensure residents' finances were safeguarded were not sufficiently robust. The provider now had a system in place to ensure that residents finances were appropriately managed. This had been addressed following the last inspection and all money had been returned to estates of deceased residents.

Residents had access to an independent advocate and residents were invited to resident meetings. The last resident meeting was held on the 28 November 2023. Due to inadequate staffing resources, scheduled activities were only held two of the usual five days per week. On the day of inspection, many residents were observed spending long periods sitting in the communal areas without stimulation or engagement. Inspectors found that poor staffing resources impacted on how and where residents spent their day.

Residents were encouraged and supported by staff to maintain their personal relationships with family and friends. Visitors were welcomed in the centre. Inspectors spoke with a small number of visitors and in the main, all were complimentary of the care provided to their relatives. Some visitors spoken with reflected the concerns identified in this report, such as fire safety and the management of complaints.

Regulation 28: Fire precautions

The provider had failed to take action to address the significant non-compliance found following the previous two inspections. An action plan addressing the high risk findings of a fire risk assessment in November 2021, had not been progressed.

Compliance plans submitted by the provider following the previous inspections were not in progress. The upper floor of the centre had limited compartmentation. This meant that in one compartment there was the risk that up to twenty residents could require evacuation from this area in the event of a fire. The commitment made by the provider detailing the works and upgrade that was required to bring the centre into compliance with Regulation 28: Fire precautions, had not been commenced. This meant the risks associated with the current structure of the premises remained. In addition, mitigation measures had not been sustained. For example;

- Inspectors found that the staff responses in what action they would take in the event of the fire alarm sounding were poor and inconsistent.
- Safety checks on fire equipment had not taken place since June 2023.
- Residents documentation displayed on their wardrobe doors, detailing their personal emergency evacuation procedures were not always kept up to date.
- Fire drill records lacked the detail required to provide adequate assurance of resident safety.
- Fire safety documentation lacked a clear description of the action to take in the event of the fire alarm being activated.
- Fire procedures displayed in the centre were not accurate. Signage on the ground floor directed staff, on the sounding of the fire alarm, to the fire panel at reception. However, some staff informed the inspectors that they were to attend the fire panel on the first floor, while other staff were not clear on which fire panel they would go to.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Individual assessments were not always completed to ensure a comprehensive assessment of residents needs. Residents personal fire evacuation plans and assessment of residents with responsive behaviours were incomplete and therefore did not inform an appropriate care plan to guide staff to deliver safe and effective care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP). The person in charge confirmed that the residents doctors were visiting the centre as required.

Judgment: Compliant

Regulation 8: Protection

The provider had put in place measures to protect residents' finances. At the time of inspection the provider was not acting as a pension agent for any resident.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' expressed wishes and choice was not always supported and facilitated. Residents were not consistently provided with appropriate recreational and stimulating activities to meet their needs and preferences. For example:

- At the time of inspection, there was social care activities scheduled two days a week. While inspectors were informed that the health care staff provide meaningful activities to the residents in the absence of activities staff, this was not apparent on the day. While staff were observed supervising communal rooms, inspectors observed the staff were not using this opportunity to provide meaningful social engagement.
- A resident was unable to attend a religious service of their choice. This was due to inadequate staffing resources.

Judgment: Not 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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Aperee Living Galway OSV-0000331

Inspection ID: MON-0042039

Date of inspection: 29/11/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Currently Aperee Living Galway has the required complement of Nurses to fill the Nurse roster Staff roster deployment has been reviewed to ensure appropriate staffing is available on the ground floor. To support a positive dining environment in the centre, the Person in Charge will ensure that an adequate number of staff are available to assist residents who may need help with their meals in a timely manner. This will be ensured by supervising the dining environment by a member of the management team and close collaboration between the resident, nursing team and catering team will be fostered to ensure residents' necessities are facilitated.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Subsequent to inspection the RPR, in conjunction with the Person in Charge have accessed supervision requirements in the home to ensure positive outcomes and quality services to residents by: • Ensuring DON and ADON hours are on a full time supernumerary position • Staff will be provided with access to support and advice.	

• Performance improvement plans implemented where required.
• Staff meetings and input held on a more regular basis than previous thus ensuring more effective communication.

In addition, the Person in Charge will ensure that staff have access to appropriate training, will work closely with the care team to identify any further training needs.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Three new company directors were appointed. One of the new Directors has also been appointed as Registered Provider Representative of the Company. The 3 new company directors are all actively involved in the management of the company and one of the directors is also a Regional Clinical Manager.

The new consortium took over the management of the home on November 20th 2023 and have already held numerous formal management meeting with the Home team and the new governance structure has been outlined and communicated to all staff.

All management systems in place will be updated to ensure the service provided is safe and adequately monitored. This will be achieved through the implementation of frequent auditing and KPI analysis and trending.

Areas highlighted under Governance and Management are outlined separately in this response under each appropriate Regulation.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
A Complaints Procedure Audit has been completed by the Person in Charge and an action plan in place to address all identified areas of non-compliance.

The Person in Charge will ensure:

• the detail of complaints will be fully recorded.

• complaints will be investigated, closed off in a timely manner and actions taken as a result of the complaint documented.
• the satisfaction level of the complainant will be recorded.

All complaints will be used as an opportunity for learning and quality improvement plans identified will be communicated to all staff.

Regular audits shall be undertaken to determine compliance to the homes complaints policy and procedure. Results of audits will be presented to the nursing team.

In addition to the above, monthly KPIS to include Complaints Management has been implemented to identify performance patterns and Quality Improvement Plans will be completed based on the identified trends. This will be ongoing.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A Contractor has been appointed and he is currently mobilising his team with rectification works commencing in early February 24, with an anticipated completion date of end of May 2024.

Weekly audits on the fire evacuation equipment completed regularly by the maintainence man and secondary checks have recommenced using 2 specifically nominated team members..

Educational sessions on fire safety are completed twice daily during both nighttime and daytime following inspection and PIC/ADON ensured that all staff were in attendance. PIC/ADON/CNM completed sessions. Ongoing weekly sessions will continue along with regular auditing of staff familiarisation.

Emergency Plan was updated to reflect the practices in the home and implemented on the 08/12/2023.

Full review of PEEPS completed by PIC and PEEPS are displayed on Computer system, residents wardrobe along with a copy at main fire panel and secondary panels in each nurses station. PEEPS folders are broken down into compartments.

existing signage was reviewed to ensure it matches the plan and the practice.

Additional user friendly signs placed in prominent areas which outline the proceedure to follow when a fire alarm goes off and actions to be taken.

Fire Drills and practice sessions completed every second day for 2 weeks following the inspection and record kept.

Fire Drills and practice sessions will continue at regular occassions until completion of any remedial works and will continue then at least 4 times per year in line with national reccomendations.

Fire training completed on the 6th December 2023 with external trainer and PIC met with him prior, to review topics covered and ensure the plan matches the practice.

All staff are up to date with Fire training as evidenced by training matrix held in the center and further sessions will be scheduled in 2024 to ensure all staff remain up to date.

All incoming staff are scheduled on the fire training.

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:
All Personal Emergency Evacuation Plans have been updated and PIC/ ADON will monitor all to ensure they are up to date with current and relevant information.

All responsive behaviors are documented through incident reporting, ABC charts are utilized to establish root causes and triggers.

Care plans will be updated and reflective of behaviors which will identify triggers and interventions by 31.01.2024

Responsive behavior training provided in house to capture all staff with regular sessions planned for the coming year.

Staff Nurse meeting held and responsive behavior topic on the agenda. Will remain an agenda at all care team and clinical meetings. All staff re-educated on the Responsive behavior approach to care model with reminders and discussions at handovers following documented incidents.

Regulation 9: Residents' rights	Not Compliant

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

Aperee Living Galway are recruiting an activities Co-ordinator. Activities person will be responsible for the provision of planned activities which will be meaningful to the residents. Activities are be designed to promote positive health and mental wellbeing.

Activities person will be separate to the health care team and will be specific to the role.

In the interim a member of the existing team will assume the role and will commence the role full time on the 15th January 2024.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	01/01/2024
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/01/2024
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/01/2024

Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/01/2024
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	31/01/2024
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	31/05/2024
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/05/2024
Regulation 28(1)(c)(ii)	The registered provider shall make adequate	Not Compliant	Red	06/12/2023

	arrangements for reviewing fire precautions.			
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.	Not Compliant	Red	06/12/2023
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 procedure to be followed in the case of fire.	Not Compliant	Orange	20/12/2023

Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2024
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	31/05/2024
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Not Compliant	Red	06/12/2023
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	31/01/2024
Regulation 34(3)	The registered provider shall take	Not Compliant	Orange	31/01/2024

	such steps as are reasonable to give effect as soon as possible and to the greatest extent practicable to any improvements recommended by a complaints or review officer.			
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Not Compliant	Orange	31/01/2024
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's	Substantially Compliant	Yellow	31/01/2024

	admission to a designated centre.			
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	31/01/2024
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	15/01/2024
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	15/01/2024