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:	Marymount Care Centre
Name of provider:	Humar Limited
Address of centre:	Westmanstown, Lucan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	16 August 2023
Centre ID:	OSV-0000065
Fieldwork ID:	MON-0037206

About the designated centre

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

Marymount Care Centre is located close to the village of Lucan in West Dublin, approximately 13 kilometres from Dublin city centre. It is situated in a quiet scenic rural area. Some local amenities are available including the village shops and church. It provides long term and respite general care to male and female residents over the age of 18 years. The service is nurse-led by the person in charge and delivers 24 hour care to residents with a range of low to maximum dependency needs. The centre is comprised of a two-storey, purpose-built building containing single and twin bedroom accommodation for up to 140 people, the majority of which include private en-suite toilet and shower facilities. Communal areas include spacious and homely dining and sitting rooms and multiple other rest areas, library, activity rooms, and secure external garden space.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	139

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 16 August 2023	08:35hrs to 19:45hrs	Lisa Walsh	Lead
Wednesday 16 August 2023	08:35hrs to 19:45hrs	Frank Barrett	Support

What residents told us and what inspectors observed

Inspectors spoke with a number of residents in the designated centre to gain insight into their experience of living in Marymount Care Centre. Residents were complimentary of the staff and the care they received. Residents said they felt safe living there and had no complaints. If they did have a concern they would feel comfortable and confident to raise this. Staff were observed to be familiar with residents needs and respectful of their wishes. Interactions between staff and residents were observed to be kind, friendly, patient and jovial, demonstrating how comfortable they were with each other.

Following an introductory meeting with the person in charge and registered provider representative, inspectors viewed the communal space in the Maple lounge on the ground floor of the centre. Work had been recently completed to increase the communal space for residents, and then inspectors viewed the remainder of the designated centre.

The centre is set out over two levels, with access between levels via a lift or stairs. Residents were accommodated in 88 single and 17 twin occupancy bedrooms, with en-suite facilities. The remaining beds are in ten single rooms and two twin rooms as well as two twin bedded apartments. Residents' bedrooms were personalised, homely and clean. There were communal rooms throughout the centre for residents to sit and relax in. The centre also had a number of secure gardens that residents could access.

Improvements had been made to the centre to increase the communal space in the Maple Lounge. The newly decorated extension had large windows which opened out onto a manicured garden and brightened up the communal space for residents. However, access to this garden was keypad locked which meant that residents who wished to use the garden required the support of staff.

The centre was clean and bright with a very relaxed, pleasant atmosphere and was well-maintained. The corridors were spacious with residents seen to spend time walking freely throughout these areas. The communal rooms were well-decorated, spacious and very homely.

Many of the communal areas and dining rooms throughout the centre had large windows with views out onto the well-manicured gardens and countryside surrounding the centre. On the morning of inspection, there was a reminiscence activity featuring radio and television from the 1940's to the 1970's. This was well-attended by residents, who joined in with enthusiasm and enjoyed tea and soup while participating.

Many of the residents were observed to eat in the dining rooms throughout the centre for their meals. Dining room tables were well-laid and dressed with flowers in a vase. Menus were available on each table for residents to choose their meals from.

While residents ate their meal there was soft music playing in the background and several staff available to assist residents with their meal. Overall, residents spoken with said the food was very good, there were lots of options for them to choose from and the food options changed everyday. Residents also said they also got large portions of food and there was always more food available to them if they wanted. The food was observed to be piping hot and smelled appetising.

Residents were observed to be receiving visitors with no restrictions throughout the day. Visitor spoken with were very complimentary of the care their friends and relatives received and had no complaints.

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

Capacity and capability

While there were established management structures to support staff in this designated centre, inspectors found that some improvements were required in the management systems for the effective oversight of the fire precautions, premises, directory of residents and information guide for residents. Although there were improvements made to assessments and care planning since the last inspection in March 2023, further action was required to come into compliance with the regulations.

This unannounced inspection was carried out over one day by two 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) and to inform a decision on an application to vary Conditions 1 and 3 of the centre's registration. A completed application to extend and divide the Maple unit and create two communal areas instead of one had been received by the Chief Inspector prior to the inspection and was under review. On the day of inspection, inspectors were informed that further proposed works had also commenced.

Marymount Care Centre is operated by Humar Limited which is the registered provider. The person in charge facilitated this inspection and demonstrated a good knowledge of the legislation and a commitment to providing a good quality service for the residents.

This inspection found that there was a clearly defined management structure in place. Inspectors saw that systems were in place to manage risks associated with the quality of care and the safety of the residents. The person in charge was supported in their role by two assistant directors of nursing, clinical nurse managers,

nursing staff, carers, activity staff, maintenance and catering teams.

The registered provider had audit and monitoring systems in place to oversee the service. Actions identified for quality improvement were assigned to a responsible person, with times for completion noted. Updates on these actions were discussed in management and staff meetings. However, management and staff meetings were not taking place as scheduled in all units. On the day of inspection, staff were also unaware of the the schedule of meetings for when these were to take place. For example, management meetings were due to take place every two weeks however, the records reviewed did not reflect this.

The registered provider had established a number of committees to drive improvement. For example, a medicine management and a restrictive practice committee had been established and were meeting frequently. The restrictive practice committee was working towards reducing the use of restraints within the centre, with significant work completed.

Inspectors reviewed the procedures that were in place at the centre to protect residents from the risk of fire. Some good practice was in place to ensure that fire safety concerns were being highlighted with daily, weekly monthly and annual checks of various systems. The provider had procured a fire door assessment of the centre which identified some areas of fire safety concern. The provider had actioned some of these issues, and had a works plan in place to carry out the remedial works to address the remaining issues. However, there were further concerns relating to staff training and fire drill records including fire safety policy at the centre. These are discussed further under Regulation 23; Governance and Management and Regulation 28; Fire Precautions.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

An application to vary condition 1 and 3 of the centre's registration was received by the Chief Inspector. The application was complete and contained all of the required information.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents did not include all of the information that is required under Schedule 3 of the regulations. For example:

- the gender and marital status of the resident was not included in some records reviewed.
- the general practitioner's (GPs) contact address was not included in some

records.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems were found to be insufficient to ensure that all areas of the service provided were safe, appropriate, consistent and effectively monitored. For example:

- On review of some policies in place it was not clear when these had been adopted and implemented as they were not dated or signed by the registered provider. For example, the centre's restrictive practice policy had no date to say when the policy was effective from, no review date date and there was no signature from the registered provider to say the policy had been approved for use in the centre.
- There was no current fire safety policy in place at the centre. When this was brought to the attention of the provider, inspectors were informed that a new policy was being formulated. This policy was enacted and signed into use before the end of the inspection.
- A recorded fire drill at the centre identified areas of failure during the course of that drill. There were concerns raised relating to the inaccurate information posted on the fire alarm panel, the failure of the automatic gas shut off to activate, failure of automatic door closers to activate in all areas, and staff knowledge of the procedure. There was no record to show that these issues were resolved following this drill. Some later fire drills did not record the detail of the fire drill including length of time to evacuate to safety, the scenario that was trialled, the numbers of staff involved or the compartment which the drill was completed in. This was contrary to the new and the previous policy at the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure in the centre. This was displayed throughout the centre. There was a nominated person who dealt with complaints and a nominated person to oversee and review the management of complaints.

The centre considered all feedback received both verbal and written and there was evidence of effective management of the complaints viewed with the satisfaction of the complainant recorded.

Judgment: Compliant

Quality and safety

Overall, this was a good service that delivered good quality care to residents and resident appeared well cared for. However, inspectors found that some action was required for some care plans to ensure that a quality and person-centred service was provided. This was also identified in the previous inspection in March 2023. Action was also required in relation to Regulation 17: Premises, Regulation 20: Information for residents and Regulation 28: Fire Precautions as described under their respective regulations.

Residents told the inspector that they felt safe and happy living in the centre. Staff were observed to speak with residents in a kind and respectful manner, and to know their needs very well. Records seen on inspection showed that there was consultation and inclusion of the residents in the running of the centre. The recreational opportunities available to residents were adapted to meet their needs and were person-centred.

A sample of care plans and assessments for residents was reviewed. Since the last inspection in March 2023 a new holistic care plan was introduced which was person-centred and clearly detailed the care to be provided. However, this was not in place for all residents as set out in the compliance plan. The preparation and review of care plans also required some action, this is detailed under Regulation 5; Individual assessment and care plan.

Documentation related to the use of restricted practices in the designated centre was reviewed by inspectors. The information was clear and reviewed by the person in charge on a regular basis. However, the restraint register in place did not have chemical or environmental restraints recorded.

The inspector observed water fountains placed in each dining room throughout the centre and snacks were frequently offered to residents. Residents were offered refreshments throughout the day. A sample of menus were reviewed which showed a four-week menu rotation with a variety of food choices each day. The menu options were also available for residents on a modified diet or sugar-free diet, to ensure dietary requirements were being met. Residents expressed satisfaction with the choice of food and they assured the inspector that it was enjoyable.

Inspectors reviewed the premises both internally and externally. The centre was clean and well maintained, however,some issues relating to storage and inaccurate floor plans was identified on inspection. Some areas of the centre deviated from the registered floor plans. While storage was available in residents' rooms, many rooms did not have lockable storage available. These findings are detailed further under Regulation 17; Premises.

The registered provider had prepared a residents' guide in respect to the designated centre, this was provided to inspectors. The person in charge had liaised with advocacy services, however, all details required under the regulation were not clearly detailed in the booklet.

Inspectors reviewed the arrangements at the centre to protect residents from the risk of fire. Maintenance of fire safety systems and equipment was available on the day of inspection. While most fire doors throughout the centre were well-maintained, some issues were identified relating to fire sealing and doors not fully closing. It was observed throughout the inspection that all bedroom doors were fire doors, but none were fitted with door closers. Fire drill records reviewed during the inspection revealed that the procedure for evacuation was not clear to all staff.These issues are detailed under Regulation 28; Fire precautions.

Regulation 17: Premises

The registered provider did not ensure that the premises of the designated centre was in accordance with the statement of purpose prepared under regulation 3. Discrepancies were identified between the registered floor plans, and the situation at the centre for example:

- a store room on the St. Francis wing was labelled and identified as a bathroom on floor plans
- the stairs at the front entrance were identified as being in the enclosure of the lobby. In reality, these stairs were contained in a stairwell to the side of the lobby.
- a door near the St. Francis elevator identified on the floor plans, was not in place.

The registered provider did not, having regard to the needs of the residents at the centre, provide premises which conform to all the matters set out in Schedule 6 of the regulations. For example:

- there was no lockable storage in some bedrooms. Inspectors were informed on the day of inspection that lockable storage is available to those that request it.
- storage issues were found throughout the centre. Inappropriate storage was found in elecrical distribution cupboards. Other store rooms had materials and boxes stored on the floor. This would present difficulties for cleaning these areas. Another store room was overfilled with items ranging from mattresses, bins and a radiator. It was not possible to access most of the items within the store room.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents expressed overall satisfaction with food, snacks and drinks. Residents had access to fresh drinking water. Choice was offered at all mealtimes and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. Residents' dietary needs were met. There was adequate supervision and assistance at mealtimes. Regular drinks and snacks were provided throughout the day.

Judgment: Compliant

Regulation 20: Information for residents

The residents' handbook did not contain information regarding independent advocacy services nor the procedure for the external complaints process such as, the Ombudsman.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider did not take adequate precautions against the risk of fire in all areas, and did not provide suitable fire fighting equipment for example:

- There was no record of cleaning of the ductwork and extractor hood in the kitchen. Cooker hoods can be a source of ignition due to the build-up of grease therefore oversight is required.
- Storage issues were impacting of fire safety as some storage areas had flammable and combustible materials stored together, which was contrary to local policy.

The registered provider did not ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the centre are aware of the procedure to be followed in the case of fire. For example:

- Fire drills were being recorded at the centre, however, in some cases the detail of the scenarios, times, and participants of the drills were not being recorded. This would make tracking improvement difficult, or errors identified at fire drills going unresolved.
- One fire drill was stopped after 20 minutes, with recorded confusion relating to staff responsibilities. This reflected a lack of training in the procedure, and

a lack of knowledge in the use of evacuation aids and fire safety equipment.

Improvements were required to ensure that adequate arrangements were in place for containing fires for example:

- Some bedroom doors and other doors in the centre were not fitted with door closers. In the absence of door closers, doors should be closed when the room is not in use in order to contain fires that may start in the room. Open doors were found in many rooms throughout the centre that were not in use at the time. A door was found wedged open to the kitchenette in the St Francis wing.
- There was no evidence of fire sealing of an under stairs storage area in the St Francis wing. This would mean that a fire in this area would not be contained, and smoke/fire could spread to the adjoining stairwell.
- Inspectors were not assured that fire containment measures were in place in the attic space above as attic hatches which did not appear to be fire-rated. This would mean that fire could spread into the attic space, and further across compartment lines in the attic.
- Cabinets in hallways in the St. Anne's wing were not fire-rated cabinets. These cabinets stored items ranging from linen and towels, to personal protective equipment (PPE) and aerosol cans. The lack of containment on these cupboards would impact on the escape route from this bedroom corridor.

Improvements were required to provide adequate means of escape, for example:

- A disabled refuge area on a first floor stairwell was fitted with a cabinet. This cabinet contained PPE and hand gel. The cabinet was not fire-rated. This would impact on the ability of staff to use the disabled refuge area during an evacuation.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Notwithstanding the improvements noted since the last inspection, some further action was required in individual assessment and care plans to ensure the needs of each resident were assessed and an appropriate care plan was prepared to meet these needs. For example:

- A small number of care plans were not formally reviewed at intervals not exceeding four months.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging
Residents who displayed responsive behaviour (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) were seen to have appropriate and detailed supportive plans in place to ensure the safety of residents and staff.
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 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Marymount Care Centre OSV-0000065

Inspection ID: MON-0037206

Date of inspection: 16/08/2023

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 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: An audit of the current directory of residents has been completed. This audit identified a small number of residents who had their gender not specified and those who had no full address of their GP documented has now been updated and completed. The directory has subsequently been updated and now includes all the information specified in paragraph (3) of Schedule 3. A quarterly audit on the Directory of Residents will take place to monitor ongoing compliance.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All current policies are being reviewed and audited to ensure that they have been dated, approved, signed, and have a review date. This audit will be conducted on a annual basis to monitor ongoing compliance. There is a restraint register in place which includes all restraints in use at the center including chemical restraints. This is reviewed and monitored on a monthly basis at the Restrictive Practice Committee meeting.	

The Environmental restraint referenced in this report related to the use of keypads in our Dementia friendly unit and are required for safety and security of our residents.

The environmental register in place now includes the use of Keypads. The monthly audit on the use of all types of restraints used will continue to be monitored at the monthly Restrictive Practice Committee meeting.
Fire:
The inaccurate information posted on the fire alarm panel following this fire drill has now been rectified as of the 12th September 2023.
During this fire drill there was a failure of automatic gas shut off, this was reviewed by an external company on 15th September and now has been rectified and is operational.
Automatic door closers: An external competent person in Fire has been engaged with to review the current fire certificate. This will include a review of how the new building and existing building responds when there is a fire activation. Currently automatic door closers are activated in alarm activated areas. This will be reviewed as par of our new fire certification. The increase in frequency of fire drills (day and night duty) this will enhance the staff knowledge on the procedures to be followed.
All fire drills now include detail of the scenario, length of time to evacuate to safety, the numbers of staff involved and the compartment which the drill was completed in.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Marymount Care Centre's floor plans have been updated to reflect the footprint of the centre and the SOPF has been updated also. The SOPF will be audited on an annual basis to ensure compliance is maintained.

An audit of all bedrooms was carried out and identified 10 bedrooms that did not have individual lockable storage available. These lockers are now being fitted with individual lockable storage An audit was carried out of all storage areas throughout the building, issues that were identified on the day of inspection have now been rectified as set out in schedule 6 of the regulations.

A monthly audit will be conducted to ensure compliance on storage areas is maintained.

Regulation 20: Information for residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:
The residents' Guide has been updated and now contains all information regarding independent advocacy services and the procedure for the external complaints process, including the Ombudsman. An annual audit of the Resident's Guide will be conducted to ensure ongoing compliance is maintained.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Kitchen duct work. A service contract has been entered into with a company now contracted to clean duct work and canopy on the 16th Oct 2023 or sooner should a cancellation occur. This service will be monitored to ensure it is done twice a year therafter.
Storage areas: All storage areas were audited and a work program completed to ensure flammable and combustible materials are not stored together. All items stored are shelved and stored at a workable height. A monthly audit will be carried out on all storage areas to ensure oversight and compliance is maintained with same.
All fire drills include detail of the scenarios, times, and participants of the drills.
Fire drills of the largest bedroom compartment and night time drills are included in our monthly fire drill routine going forward.
The increase in frequency of fire drills (day and night duty) this will enhance the staff knowledge on the procedures to be followed, use of evacuation aids and fire safety equipment.
Door closers: Whilst 50 bedrooms have automatic closers, staff are instructed to close doors of rooms that do not have an automatic closer throughout the centre This is now included in our mandatory fire training
The daily means of escape checklist provides oversight and monitoring to ensure there are no door wedges being used.
Fire sealing in stairwell : storage items have been removed until implementation of fire seal on under stairs compartment. A daily audit is being carried out to ensure this area is free of items until the implementation of fire sealing is complete.
Fire containment in attic spaces : An external company has been engaged with to verify that all attic hatches are fire rated.
Cabinets in hallways: All storage items have been removed and cabinets are sealed.

Disabled refuge area storage – items have been removed to fire compartment until a new storage with fire doors is installed.

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The resident's admission checklist that was revised and implemented in April 2023 following previous HIQA inspection continues to be utilised and monitored to ensure compliance.

The auditing system in terms of oversight of Individual care plans continues to be monitored monthly to ensure all care plans are formally reviewed at intervals not exceeding four months.

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(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	20/09/2023
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	27/10/2023
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	20/09/2023

Regulation 20(2)(e)	A guide prepared under paragraph (a) shall include information regarding independent advocacy services.	Substantially Compliant	Yellow	17/08/2023
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include the procedure respecting complaints, including external complaints processes such as the Ombudsman.	Substantially Compliant	Yellow	17/08/2023
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	16/10/2023
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.	Substantially Compliant	Yellow	16/10/2023
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	29/09/2023

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	29/09/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	29/09/2023
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	21/09/2023