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:	Maryfield Nursing Home
Name of provider:	West of Ireland Alzheimers Foundation
Address of centre:	Farnablake East, Athenry, Galway
Type of inspection:	Unannounced
Date of inspection:	13 November 2019
Centre ID:	OSV-0000359
Fieldwork ID:	MON-0024740

About the designated centre

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

Maryfield Nursing Home is a designated centre that provides long term and respite care for 24 male or female residents who have dementia or a related condition. Day care for up to four people is also provided.
The centre is located in a rural setting approximately two kilometres from the town of Athenry and 25 kilometres from Galway city. The centre is purpose built. It is single storey and residents' accommodation is provided in 12 single and six double rooms. There is adequate sitting and dining space to accommodate all residents in comfort. A safe garden area is also available. The environment has been enhanced by the use of dementia friendly features that include signage, good levels of natural lighting and a homelike layout.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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
13 November 2019	17:30hrs to 20:00hrs	Una Fitzgerald	Lead
14 November 2019	09:00hrs to 17:00hrs	Una Fitzgerald	Lead
15 November 2019	14:30hrs to 15:00hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

On arrival at the centre the inspector was met by the person in charge. Residents were in the day room and some were mobilizing around the various parts of the centre. There was a relaxed atmosphere with staff observed assisting residents in a respectful and unhurried manner.

The centre admits residents with a diagnosis of dementia. The inspector observed that staff chatted freely with residents on topics of interest to them. There was a stable staffing workforce which meant that the staff were familiar with the likes and dislikes of the residents. The inspector observed there was a range of stimulating and engaging activities that provided opportunities for socialisation and recreation. The centre had staff appointed for the provision of activities. From conversations had with staff, the inspector observed that all staff had a good understanding in their role and responsibility regarding normal socialisation and engagement with residents. Staff considered activities an important part of their role to ensure residents were comfortable and at ease in the environment.

Overall, the design and layout of the building allows residents to move between rooms and along corridors freely. The communal sitting room and dining room was a hub of activity during the inspection. The inspector observed that the communal room is supervised at all times by a member of staff. The interactions observed between the residents and the staff were kind, patient and respectful. The activities team were observed carrying out one to one activities such as hand massage, playing cards and making jigsaws.The inspector spoke with individual residents and found that they were happy in their environment. Residents were seen to enjoy their meals and from observations made, meals were a social activity.

Capacity and capability

The centre is managed by West of Ireland Alzheimers Foundation. Management Systems in place required significant review to ensure the service provided was safe, appropriate,consistent and effectively monitored. The systems which required review were the responsiblity of the registered provider representative. Clinical management and oversight on the delivery of resident care was provided to a good standard.

Judgments of not compliant found on this inspection were the responsibility of West of Ireland Alzheimers Foundation. This was evidenced by:

- Failure to provide 24 hour access to hot water in all areas of the premises.
- The inspector had to request that Garda vetting disclosures be brought to the centre for inspection and be kept on staff files in the centre for future reference.
- Repeated non compliance from the last inspection that had not been sufficiently progressed.
- The risk register required review to ensure it was updated to reflect the current risks in the centre.

The inspector was satisfied that the direct care delivered to residents was of a good quality, person centred and effectively monitored. The inspector found that the residents were content in their living environment and were cared for by a team of professionals who knew their needs.

The person in charge facilitated the inspection process by providing documents requested in a timely manner and in an easily understood format. The clinical management team displayed good knowledge of residents' care and conditions. The person in charge was focused on developing a culture of quality improvement and learning to drive improvements in the standard of care delivered to residents. Following the last inspection, the person in charge had further developed the auditing system that was in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. Clinical care audits had been completed on falls management and medication management. When gaps were identified, further actions where taken, followed up and closed off once completed.

The design and layout of the building means that there are 21 residents sharing two bathroom and shower facilities. The inspector was informed that there has been an ongoing issue with the continuous supply of hot water for resident use in the centre (with the exception on the new extension). The inspector reviewed the governance and management meetings and there was clear documentary evidence that this issue was escalated and known to senior management. The situation at the time of inspection was that residents did not have access to hot water 24 hours a day in the communal bathrooms to allow for showering. As a result, staff confirmed that showering was not always an option. Current practice on these occasions meant that staff accessed hot water in the laundry room. The impact for residents was a bed bath rather than a shower.

This issue was discussed with the provider representative and the inspector requested that the registered provider representative submit what action was going to be taken, within an acceptable time to resolve the hot water supply over a 24 hour basis in all areas of the centre. This request for clarity was received. The provider representative committed to ensure that the system would have ability to provide hot water 24 hours a day throughout the building by the 26th November 2019. At the time of writing this report this reassurance had been received from the provider representative.

The inspector reviewed a sample of staff files. The inspector was informed that evidence of Garda vetting was not kept on site and was securely stored at a separate location. This meant that the local management team did not have

the oversight that all staff had a valid Garda vetting on file. The registered provider was requested to make all Garda vetting documents available for review which was actioned on the day.

The inspector followed up on the actions required from the last inspection carried out in March 2018. The inspector acknowledges that some progress has been made. However, there are four repeated non compliance found under regulations 16 Training and staff development, regulation 24 Contract for the provision of service, regulation 17 Premises and regulation 28 Fire precautions. In addition regulation 23 Governance and Management and regulation 26 Risk management are judged as not compliant. The detail of the non compliance is provided under each regulation listed below.

Regulation 15: Staffing

Sufficient numbers of staff with appropriate skills were available to meet the assessed individual and collective needs of residents in the centre. A planned and actual staff rota was available. The roster reflected the staff on-duty on the day of inspection.

A full review of the allocation of duties had been completed by the nursing management team following the last inspection. This review has had a positive impact on the overall quality of lives and delivery of care. For example, the communal sitting and dining room is now supervised at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to appropriate training and records reviewed evidenced that all staff had received training in safeguarding and safety and fire safety. While minor gaps were seen in training in manual handling training staff were booked in to attend training that would address any gaps. Following the last inspection a training matrix was developed. This record required further development to ensure that it was current.

Judgment: Substantially compliant

Regulation 21: Records

The inspector reviewed staff files and found compliance with Schedule 2 regulation requirements. As stated, the inspector identified during the inspection that Garda vetting disclosures in place were not stored in the centre and so were not available for review. The inspector acknowledge immediate action taken by the provider representative during the inspection ensured that the centre was compliant.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place that identified the lines of authority and accountability.The management systems in place required review to ensure the service provided was safe, appropriate, consistent and effectively monitored. This is evidenced by:

- Failure to ensure that residents and staff have 24 hours access to hot water
- Failure to maintain a risk register that monitors known risk within the centre.For example: infection control risk due to staff not having 24 hour access to hot water in all parts of the centre.
- Failure to adequately address the judgements of non compliances found from the last inspection in March 2018. There are four regulations that are restated as substantially compliant or not compliant.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Each resident had a written contract of care agreed with the provider which outlined the services provided. Following the last inspection the management had reviewed the detail in the contract of care. The wording was amended to identify that the room may be single or double occupancy. The inspector reviewed three contracts. The type of room to be occupied was not specified.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was dated September 2019. Further detail is required to ensure that the Statement of Purpose is accurate and contains all of the information set out in Schedule 1. Further detail is required on services which are to be provided by the registered provider to meet resident care needs. For example, how residents access services that are provided under the medical card scheme.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The centre had a policies folder required by the regulations within the centre. The index identified all policies that are required by the regulations. The inspector was informed that all policies were available. However, on the days of the inspection there was five of the policies required by the regulations not available.

Judgment: Substantially compliant

Quality and safety

The inspector reviewed several regulations related to the quality and safety of the service delivered to residents. Overall, the inspector found good evidence that residents were receiving quality care delivered by a multi-disciplinary team. The inspector reviewed resident files relating to assessments, care planning, access to healthcare, maintenance of records and policies available governing care. Following the last inspection nurse management had reviewed the care planning system in place and were in process of implementing a new documentation system.

The new care planning system in place was clearly outlined and easily navigated. This meant that staff could efficiently and effectively learn about residents under their care. This in turn ensured that care was delivered in line with residents' documented needs and preferences. Arrangements were in place to evaluate care plans on a four monthly basis. While there were minor gaps found, overall, the care plans reviewed were up to date. Improvement was required to evidence that the resident or their representative were involved in reviews of care plans. The inspector could track the resident journey and changes that had occurred over time. Residents had good access to allied healthcare professionals. The inspector found that advice

received and recommendations made were followed which yielded good outcomes for residents.

The centre had residents who had responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) due to their medical condition. A positive approach was taken to support these residents' care needs. Each resident had a person-centred behaviour support care plan in place that identified their support needs and informed prevention management strategies. Compassionate, sensitive and supportive care from staff positively impacted on their wellbeing and quality of life in the centre.

The centre had a large central sitting room which was homely and comfortable in its design. Activities materials, books and games were available. There was a small visitors room near the main sitting room for residents who required an alternative option away from the main communal area. Overall the premises were safe and suitable for the number and needs of residents. Corridors were safe to navigate with simple floor covering and handrails, and were free of obstructions and major trip hazards. The inspector was informed that costings have been received to upgrade a number of the wardrobes in individual bedrooms as some had been identified by the team as in need of upgrading.

Following on from the last inspection the provider had completed a review of the mechanism whereby fire doors could be kept open at residents request while remain compliant with fire regulations. The inspector observed on day one that the communal sitting room and visitors room door were kept open with a door wedge. This had allowed for residents to move freely, unrestricted around the centre. However, the doors wedged open with a door wedge is a risk in the event of a fire. Further review and installation of automatic release mechanism is required to ensure that resident movement is not unnecessarily restricted.

The inspector reviewed the management of risk within the centre. The person in charge had responsibility for updating the risk register. From the documentation reviewed,the risk register was not in line with the centres risk management policy. Risk identified during the inspection had not been identified in the risk register by the management team. For example: the supply of hot water.

Regulation 17: Premises

Residents in single and twin rooms had adequate space to store their clothes and belongings, and to personalise and decorate their room to their liking, with photographs and personal effects. Lockable storage was available in bedrooms to store valuables. In twin rooms there was suitable screening to provide privacy to one resident without limiting the use of the room for their neighbour.

As previously stated, the inspector found that the centre had a water system that did not supply hot water 24 hours a day. This issue had been ongoing and was

documented within the management meetings. The water system on the day of inspection was not fit for purpose.

The residents in the centre do not have free access to an enclosed garden. There are external gardens for resident use. Access to the gardens is through a code locked staff area and so not accessible to residents and families.

Judgment: Not compliant

Regulation 26: Risk management

A review of the risk management policy and the risk register was required. Risk identified on this inspection had not been identified on the risk register. This was evidenced by:

- The risk associated with the hot water supply.
- The risk associated with using one cloth to clean multiple bedrooms.
- The risk of fire door wedges to keep communal room doors open

Judgment: Not compliant

Regulation 27: Infection control

The centre was found to be clean. All areas of the centre including residents bedrooms were cleaned daily. Staff were knowledgeable on the cloth color coded system in place. However, the inspector found that staff were using one cloth to clean multiple rooms. The inspector spoke with staff who confirmed that there was not sufficient cloths in stock to have one cloth per room.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had taken measures to protect the residents, staff and the premises against the risk of fire. The inspector observed that suitable means of escape and emergency lighting was provided. Suitable fire fighting equipment was provided which was regularly tested, serviced and maintained. All staff had attended fire safety training. Simulated fire evacuation drills had been carried out. The person in charge committed to complete an evacuation of the largest compartment inclusive

of night time conditions.

The inspector observed on day one that the communal sitting room and visitors room door were kept open with a door wedge. This had allowed for residents to move freely, unrestricted around the centre. However, the doors wedged open with a door wedge is a risk in the event of a fire. Further review and installation of automatic release mechanism is required to ensure that resident movement is not unnecessarily restricted.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Practices in relation to prescribing and administration of medications met with regulatory requirements. Medicines controlled by misuse of drugs legislation were stored securely and balances were checked twice daily by staff.

The pharmacist who supplied residents' medicines was facilitated to meet their obligations to residents and made themselves available to answer any queries individual residents or their representative had regarding their medicines. A full medication review occurs every quarter with the involvement of pharmacist, GP and nursing staff.

Following on from the last inspection the nursing management had introduced weekly medication management audits. There was one medication administration error reported in 2019. The error did not have a negative impact on the resident. Lessons learned were identified and communicated to all nursing staff.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents had an assessment completed on admission and care plans were developed based on assessed needs. The inspector found evidence that reviews were consistently carried out every four months as per regulatory requirements.The care plans in place were person centered and guided care. Improvement was required to evidence that the resident or their representative were involved in reviews of care plans.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' health care needs were met through timely access to treatment and therapies. Residents have access to a general practitioner (GP) and allied health care professionals. There was evidence within the files that advice from allied health care professionals was acted on in a timely manner.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Behaviours associated with dementia were assessed and good practice was followed in the management of such behaviours to ensure the wellbeing and safety of residents.

The clinical team is promoting a restraint-free environment. There were systems in place to assess if a restrictive practice, such as bedrails, was appropriate to support a resident. All bedrails in use had been appropriately assessed and there was a consent form in place. The person in charge committed to update the restrictive practice register to ensure that all types of restrictive practice in place was identified. For example: the main entrance door is locked at all times.

Judgment: Compliant

Regulation 9: Residents' rights

Resident and family meetings were held frequently. Advocacy services were available to assist residents where required. The centre had recently bought a large television screen for the main communal sitting room that connected to the internet. This function was seen in use for the benefit of residents. Recreational activities in the centre were observed to be suitable and adapted to the preferences and capabilities of the current residents.

Residents rights and dignity was compromised as a direct result of the ongoing issue with the continuous supply of hot water 24 hours a day for resident use in the centre .

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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management	Not compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Maryfield Nursing Home OSV-0000359

Inspection ID: MON-0024740

Date of inspection: 14/11/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Staff Training Matrix has been updated including the removal of staff who have left the service. Manual Handling training for any outstanding staff will be completed by the 31st January 2020.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Plumber has undertaken works to ensure that there is 24 hour access to hot water in all parts of the building. • Staff Training Matrix has been updated including the removal of staff who have left the service. Manual Handling training for any outstanding staff will be completed by the 31st January 2020. • Risk register in relation to hot water not being available in all parts of the building has been updated and the risk has been closed off. • Contract of Care have been amended to specify either Single or double rooms. • Residents have free access to the garden through the door at the end of the Dining room. • Magnet releases on the two fire doors will be installed by the 31st January 2020.	

Regulation 24: Contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:
Contracts of Care have been amended to specify either single or double rooms.
The updated Contracts of Care have been forwarded to residents or their representatives for their records.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
Statement of Purpose has been amended to include detail that access to services available under the medical card scheme will be facilitated for all residents.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The five policies are now in place.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Plumber has undertaken works to ensure that there is 24 hour access to hot water in all parts of the building.
Residents have free access to the garden through the door at the end of the Dining room.

Regulation 26: Risk management	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management: A full review of the home has been taken to identify current risks and the Risk register has been updated. These include the risks in relation to hot water and one cloth to clean multiple bedrooms which have both been resolved and have been closed off. The issue in relation to fire doors has also been recorded – this will be resolved by the 31st January 2020. In the interim the door will not be wedged open.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: A system to use one cloth per room is now in place.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Magnet releases on the two fire doors will be installed by the 31st January 2020. In the interim the doors will remain closed. Nigh time fire drill has been undertaken.	
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: Resident or their representative are always involved in the preparation/review of Care	

plans – Signature sheet has been added to verify.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: Plumber has undertaken works to ensure that there is 24 hour access to hot water in all parts of the building.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/01/2020
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	31/01/2020
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	31/01/2020
Regulation 24(1)	The registered provider shall agree in writing	Substantially Compliant	Yellow	30/11/2019

	with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall reside in that centre.			
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/01/2020
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Not Compliant	Orange	31/01/2020
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of	Substantially Compliant	Yellow	30/11/2019

	healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/11/2019
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/01/2020
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose relating to the designated centre concerned and containing the information set out in Schedule 1.	Substantially Compliant	Yellow	30/11/2019
Regulation 04(2)	The registered provider shall make the written policies and procedures referred to in paragraph (1)	Substantially Compliant	Yellow	30/11/2019

	available to staff.			
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	31/03/2020
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	31/12/2019