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:	Regina House Community Nursing Unit
Name of provider:	Health Service Executive
Address of centre:	Cooraclare Road, Kilrush, Clare
Type of inspection:	Unannounced
Date of inspection:	31 March 2022
Centre ID:	OSV-0000612
Fieldwork ID:	MON-0035747

About the designated centre

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

Regina house community nursing unit is located on the outskirts of the town of Kilrush in West Clare. The centre is single storey and designed around a central, secure, enclosed garden, which was easily accessible from the corridors and day room areas. It can accommodate up to 30 residents over the age of 18 years. It is a mixed gender facility catering from low dependency to maximum dependency needs. It provides long-term residential, respite, dementia and palliative care. Bedroom accommodation is offered in 18 single and six twin rooms. Nine single bedrooms and five twin rooms have ensuite shower and toilet facilities. Nine single bedrooms in the older section of the building can accommodate residents who do not require the assistance of mechanical devices to mobilise. There was a variety of communal day spaces, including dining room, day rooms, quiet room, church, front entrance area, conservatory and family room.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	25

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
Thursday 31 March 2022	09:00hrs to 17:00hrs	Claire McGinley	Lead

What residents told us and what inspectors observed

On arrival, the person in charge of the centre guided the inspector through the infection prevention and control measures necessary on entering the designated centre. At the time of inspection there were no resident within this centre with COVID-19. The centre had experienced an outbreak of COVID-19 in the centre and had been through a difficult time. Despite the challenges faced by the centre through the national pandemic, residents who spoke with the inspectors had expressed satisfaction in the service and supports available to them.

The centre is a single-storey facility with access to a large, secure internal garden. Residents had full access to this outdoor space which also facilitated outdoor visits in a pleasant and comfortable environment. Visitors and residents had access to a kitchen to make themselves a hot or cold drink.

There was a variety of communal areas for residents to use depending on their choice and preference, including day rooms, a conservatory, visitors room with computer access, two dining rooms and a large church. The centre was registered to accommodate 30 residents. There were 25 residents accommodated in the centre on the day of inspection.

The inspector spoke with residents and also spent time in communal areas observing resident and staff interaction. The feedback from the residents was that they 'were very happy here', 'that the food was good' and that they 'can get up when they like and go to bed when they like'. Residents who were unable to tell the inspector their views on the quality and safety of the service were observed to be at ease in the environment. Most residents were observed to have had their personal care attended to a high standard. The general feedback from residents was one of satisfaction with the care and the service provided.

The inspector observed the lunch-time dining experience. The daily menu was displayed in the dining room, however this was not accessible to all residents particularly for those with poor eyesight. There were two communal dining room in use on the day of inspection. Both areas were supervised by staff when meals were being served. Modified diets were presented to the residents in appetising portions.

An activities schedule for residents was in place and staff were seen to support activities, in line with the schedule on the day of inspection. Individual activities for residents who spent time alone in their bedrooms rooms was scheduled three days per week.

Overall, the premises was observed to be in a poor state of repair. The inspector found that multiple areas of the premises were not amenable to cleaning, paint had lifted off window sills leaving exposed wood, visible gaps were observed between the window and walls in the dining room, and large gaps were observed between

the floor covering and wall in bedrooms.

A review of the bedrooms in the centre found that some of the residents who shared a bedroom had unequal access to the window compromising their access to natural light. The inspector also observed that there was a significant gap between the privacy screen and the wall which meant that the resident's privacy was not ensured.

The communal areas of the centre that were occupied by the residents were not consistently supervised by staff. There was no call bell access observed for residents in these areas. This meant that residents did not have immediate access to assistance, if required. In addition, the inspector observed that not all resident bedrooms had a call bell in place, and where a call bell was in place, the resident did not consistently have access to it. This meant that residents relied on a staff member walking past to call for assistance, if required. A resident identified that staff had asked that they use a call bell to have assistance with their mobility, however a call bell was not accessible to them when sitting in a chair in their room, the resident identified that 'they usually leave it with me'.

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

Capacity and capability

This was an unannounced risk inspection to monitor the designated centre's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) 2013 as amended. Inspectors followed up on the action taken to address the findings of the previous inspection on 28 September 2020 and on notifications received by the Chief Inspector.

The findings of this inspection were that overall, residents enjoyed a good quality of life and safe care in the centre. The inspector found that the premises and the systems in place for infection prevention and control required action to ensure compliance with regulations. In addition, the governance and oversight of a number of key areas such as fire precautions, complaints management, resident assessment and care planning, and staff training were not fully in line with regulatory requirements.

The registered provider of the centre is the Health Service Executive. There was a clear organisational structure in place with clear roles and responsibilities identified. There was a general manager who provided management oversight to the centre. The person in charge of the centre was supported by a clinical nurse manager and a team of nursing, care and support staff. The nursing management demonstrated a good awareness of the residents needs and preferences

There were governance systems in place to support the management of the centre. For example, the service was monitored by a schedule of internal clinical and environmental audits. The inspector was informed that regular governance meetings took place, however, there was no documented evidence of governance meetings that informed the appropriate monitoring and management of the service.

The staffing level on the day of inspection was appropriate for the size and layout of the centre and the assessed needs of the residents. A review of the rosters found that there was a good skill-mix of staff nurses and care assistants on duty. However, it was identified that there was a recent deficit of cleaning-staff hours. This was observed to have an impact on the cleanliness of the centre on the day of the inspection.

The inspector found that staff demonstrated appropriate knowledge, commensurate to their role. Staff told the inspector that they were appropriately supervised and supported by the management team and there was evidence of effective staff supervision including formal induction records. A staff training schedule was in place. However, review of staff training records found that not all staff had completed mandatory training including fire safety and protection training. This is discussed further under Regulation 16, Training and staff development.

A review of a sample of staff files found that they did not contain all the information required under Schedule 2 of the regulations.

A review of the complaints records showed that complaints were not managed in line with regulatory requirements or the centres' own complaints management policy. This issue is detailed under Regulation 34, Complaints procedure.

Regulation 15: Staffing

A review of the roster found that staffing numbers and skill mix were appropriate to meet the needs of the residents and the size and layout of the designated centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of staff training records found that some staff had not completed fire safety training or safeguarding older persons from abuse.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the governance and management systems were not robust, resulting in inadequate monitoring and oversight of some aspects of the service. For example:

- there were no up-to-date minutes of governance meetings available on the day of inspection between the person in charge and the general manager
- inadequate levels of staff available to ensure effective cleaning
- an annual review of the quality and safety of care delivered to the residents for 2020 or 2021 was not available for review as required under Regulation 23(d).
- staff files did not have the gaps in their employment history appropriately identified, as required under Schedule 2 of the regulations.
- inadequate oversight of infection prevention and control and the maintenance of the premises as described under Regulation 27, Infection prevention and control and Regulation 17, Premises.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

All notifications were submitted to the office of the Chief Inspector as required under Regulation 31.

Judgment: Compliant

Regulation 34: Complaints procedure

The system of complaints management was not fully in line with the requirements under Regulation 34.

- one complaint did not identify the satisfaction with the outcome of the complaint
- a complaint raised in a resident's meeting was not documented as a complaint with no record of action taken to address the complaint.

Judgment: Substantially compliant

Quality and safety

The inspector found that overall, the care and support residents received was of a good quality and ensured that the residents were safe and well-supported. Residents' medical and health care needs were met.

Staff demonstrated a good awareness of the individual care needs of the residents. However, this detailed knowledge was not consistently documented in the residents care plans. This meant that new or temporary staff or staff returning from time off did not have access to appropriately documented care plans. This issue is discussed further under Regulation 5, Individual assessment and care plans.

The inspector found that staff displayed good knowledge of the national infection prevention and Health Protection Surveillance Centre (HPSC) guidance. The provider had a COVID-19 folder that contained all up-to-date guidance documents on the management of a COVID-19 outbreak. Staff reported that the training they had received had been of a good standard and they were able to implement it in practice. The management team were committed to ensuring all reasonable measures were in place to prevent the spread of the COVID-19 virus in the centre. However, inspectors observed many areas of the premises that were not cleaned to an acceptable standard with dust and dirt evident throughout the building. Further findings are discussed under Regulation 27, Infection control.

The management of fire safety was reviewed. Quarterly servicing had been completed and there was an annual certificate for the servicing of fire fighting equipment. Staff spoken with were knowledgeable on what actions to take in the event of the fire alarm being activated. Each resident had a completed personal emergency evacuation plan (PEEP) in place to guide staff. Records documented that fire drill had been completed on a regular basis, however, the fire drills completed by staff did not provide adequate assurance that residents could be safety evacuated in the event of a fire.

Activities were available to the residents seven days per week and they included group, as well as one-to-one activities. Resident meetings were facilitated by the activities coordinator every two months, in line with the centres' policy.

There was a positive culture in the centre towards promoting a restraint-free environment for residents.

The observation and interaction between residents and staff was engaging, patient and kind. There was an obvious, familiar and comfortable rapport between residents and staff, and a relaxed atmosphere was evident.

Regulation 17: Premises

The inspector found that areas of the premises were not amenable to cleaning and were in a poor state of repair. This was evidenced by;

- paint had lifted off window sills leaving exposed wood, and varnish was worn off hand rails leaving exposed wood which was not amenable to cleaning
- exterior window sills were in a poor state of repair
- paint was peeling from skirting boards in main corridor
- visible gaps were observed between the window and walls in the dining room
- large gaps were observed between the floor covering and wall in bedrooms
- inappropriate storage of wheelchairs along communal corridors
- inappropriate storage in a communal bathroom, including items such as laundry and a hoist
- residents did not consistently have access to a call bell system in the communal areas of the centre
- one resident in shared accommodation had limited access to natural light
- a gap between the privacy screen and the wall meant that the resident's privacy in shared accommodation was not ensured.

Judgment: Not compliant

Regulation 27: Infection control

A number of issues were found during the inspection which were not consistent with effective infection prevention and control measures and are detailed below:

- dust and dirt in corners, behind fire doors, underneath radiators and on window sills
- inappropriate disposal of contaminated medical equipment
- residents equipment such as commodes and urinals was visibly unclean
- evidence of shared toiletries
- multi-tasking of staff without appropriate Infection prevention and control procedures, such as a change of uniform, posed an risk to residents. For example, a staff member was allocated laundry duties in the morning and activities in the afternoon.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire drills documented in the centre did not provide assurance that residents could be safely evacuated in the event of an emergency. For example, the fire drills recorded did not demonstrate that the largest compartment in the centre could be

evacuated with night time staffing in in a timely manner.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Care plans reviewed were not developed from the assessed care needs of the resident, for example,

- some residents who had been assessed as requiring regular pain relief did not have this aspect of care included in their care plan.
- a review of a resident who had been referred to Speech and language therapy did not have the recommendations integrated into the residents care plan.

In addition, care plan consultation with the resident and their family or representatives was not evidenced consistently in the resident's records.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were provided with unrestricted access to a general practitioner. Residents had access to allied health care professionals such as physiotherapy, occupation therapy, dietitian services and tissue viability expertise.

Judgment: Compliant

Regulation 9: Residents' rights

Resident's rights were found to be upheld and respected. The centre had facilities for activities and recreation. Residents were supported to access activities in line with their preferences and abilities. Residents meetings were held regularly allowing the residents to contribute to a variety of aspects in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Regina House Community Nursing Unit OSV-0000612

Inspection ID: MON-0035747

Date of inspection: 31/03/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• Fire safety, theory, evacuation and use of firefighting equipment –All staff completed training on 14th and 21st March 2022. Ongoing fire drills have been carried out on a monthly basis. Most recent timed fire drill took place on the 17/5/2022. All staff are now trained on fire safety.
• Manual handling training completed on the 6th April 2022
• Safeguarding training took place on 27th April 2022
• All staff training up to date on Manual Handling, Basic Life Support (BLS) completed on 28th and 29th of April 2022.
• Medication Management completed on 14th and 21st March and 11th May 2022.
• Risk Assessment education completed on 7th, 26th & 30th March 2022
• Children's first training for all staff completed on 28th March 2022
• Hand Hygiene training delivered on 18th May 2022
• Antimicrobial training delivered on 7th May 2022 on site by Regional Antimicrobial Pharmacist.
• E Learning Audit training delivered on site 17th May and online 18th May 2022 for nursing staff.

Actions to be completed :

• Additional safeguarding training is scheduled for 26th & 31st May 2022 and all staff will be trained.
• Restraint and reflective practice training scheduled for all staff on 6th & 24th May and 13th & 29th June 2022.
• Local HSE Nurse Training Centre provides care planning training and staff also complete training on line on HSEland.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Actions completed :

• There are monthly meetings held with the General Manager/Designated Officer and all the Directors of Nursing Mid West CHO Older Persons Residential Services.
The up to date minutes were not on the minute folder on site on the day of the inspection. The minutes have now being placed in the folder in the Director of Nursing Office on site.

• Deep cleaning of the designated centre was carried out on 6th, 7th, 11th and 12th April 2022 to enhance standard of cleaning. A new environmental audit was carried out, Quality Improvement Plan (QIP) devised and an adjustment made to the cleaning schedule to allow for additional cleaning at night.

• Annual review has been completed for 2021-2022 and submitted to the regulatory authority on the 6/4/2022.

• All staff files have been audited to identify any gaps in employment history. Action Plan put in place to ensure any such gaps will be updated in their respective personnel file by the 31/5/2022.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Actions completed :
• Local template has been devised to include process flow, to ensure that all complaints /grievances are identified and addressed in a timely manner.

• This local template has been discussed at team meetings, hand over/safety pause to re-iterate the importance to follow the process, document actions/owner/close off.

• All existing complaints have been closed off to present date.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A schedule of works has been developed to include painting, floor sealing and carpentry
- Tender for painting works has been issued to contractors with a closing date of 13/5/22 with an estimated start date of 6 weeks.
- Carpentry work to be completed in 4-6 weeks

• Large gaps between the wall and flooring is being repaired -work commenced on Monday 16th May 2022.

• Wheelchairs are no longer stored along communal corridors as alternative storage areas have been located on-site. Equipment is now not stored in the communal bathroom.

• At time of inspection communal bath area was used as an overflow area for storage of excess linen. This has now been rectified in consultation with the external supplier.

• Audit of Call Bells was carried out on the 6th April 2022, a Quality Improvement Plan (QIP) devised, placed in audit folder and results sent to regulatory body. All call bells are now in easy reach for each resident, who has capacity, in the communal area and at the bed side. Residents who are unable to use call bell system will have increased supervision in the communal areas of the center in the morning.

• Privacy screen in the shared accommodation room has been securely fixed in place ensuring increased privacy and dignity of residents.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Deep cleaning of the facility was carried out on the 6th, 7th, 11th and 12th of April 2022 to ensure infection prevention and control standards are adhered to. A new environmental audit has been completed and a Quality Improvement Plan (QIP) developed where adjustments have been made to the cleaning schedule to include additional cleaning at night. All residents personal and medical equipment is on a cleaning rota.

• Cleaning staff have been engaged with and re-educated regarding the revised cleaning schedule and rota.

• It is being discussed at staff team meetings, safety pause/handover that all medical equipment/devices to be decontaminated as necessary outside the cleaning of equipment/devices schedule and returned fit for use again.

• All resident's toiletries are stored in their individual presses in their en suite bathrooms.

Action to be completed :
To support the segregation of staff roles, the outsourcing of residential personal laundry to local launderette is in progress. This will facilitate infection and prevention procedures and reduce multi tasking of staff between departments.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Actions completed :

• Fire drills have been conducted weekly on the 8th, 14th and 21ststst of April in the largest compartment and submitted to the regulatory authority using night time staffing levels and timed to reflect evacuation in a timely manner.
This was coordinated with all members of staff who are rostered on night duty.

• Staff are up to date and familiar with evacuation protocols including all new staff.

• Fire safety training has been completed by all staff and learning outcomes shared with all staff.

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:
Actions completed :

• During Covid 19 the relatives, acting as advocates for some residents, had been unable to attend the CNU to sign care plans (due to restrictions) but had been involved verbally, will now sign as confirmation of consultation. This will be completed by 31/5/2022.

• The residents/relatives input to the care plans is valued and supported, which enhances the residents experience.

• Care plans have been audited, Quality Improvement Plan devised and education on care planning is ongoing.

• Regular pain relief, for those residents that have been assessed will be documented in the Care Plan. A Quality Improvement Plan (QIP) has been devised assigning actions to the key worker to follow-up.

• It is recommended that the allied health professionals (AHP) notes are clearly attached as an appendix to the Care Plans which is recommended for accuracy and reduce risk of transcribing errors. The AHP report is part of the Care Plan folder and all staff are advised of same.

• There is a regular auditing schedule for care planning in place. Recent E Learning Audit training delivered on-site on 17th and online on 18th May for nursing staff. This will allow nursing staff to familiarize themselves with the new audit tool, educate them and improve standards for individualized care plans.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	30/06/2022
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	15/07/2022
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Substantially Compliant	Yellow	09/05/2022
Regulation 23(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	09/05/2022

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 23(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care delivered to residents in the designated centre to ensure that such care is in accordance with relevant standards set by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act.	Substantially Compliant	Yellow	31/05/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	30/05/2022
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the	Substantially Compliant	Yellow	09/05/2022

	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.			
Regulation 34(1)(f)	The registered provider shall provide an accessible and effective complaints procedure which includes an appeals procedure, and shall ensure that the nominated person maintains a record of all complaints including details of any investigation into the complaint, the outcome of the complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	09/05/2022
Regulation 34(2)	The registered provider shall ensure that all complaints and the results of any	Substantially Compliant	Yellow	09/05/2022

	investigations into the matters complained of and any actions taken on foot of a complaint are fully and properly recorded and that such records shall be in addition to and distinct from a resident's individual care plan.			
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	09/05/2022
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	09/05/2022