Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	St Teresa's Nursing Home
Name of provider:	Cashel Care Limited
Address of centre:	Friar Street, Cashel, Tipperary
Type of inspection:	Unannounced
Date of inspection:	27 November 2024
Centre ID:	OSV-0000293
Fieldwork ID:	MON-0045369

About the designated centre

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

St. Teresa's Nursing Home is centrally located in the town of Cashel, Co. Tipperary and is in close proximity to all facilities such as the church, shops and restaurants. The original premises dates back to the 1800's and was formerly a convent that had been refurbished and modernised. The centre originally opened to provide residential care in 2003 and caters for both male and female residents over the age of 18 years and is registered to provide care to 30 residents. Twenty four hour nursing care is provided with a registered nurse on duty at all times. The centre accommodates low, medium, high and maximum levels of dependency including residents that may be ambulant and confused. Communal accommodation in the form of dining and day rooms are on the ground floor and bedroom accommodation is on the first and second floors. There are three single bedrooms and six twin bedrooms on each floor. The registered provider is a limited company called Cashel Care Ltd and employs approximately 30 staff. Staff employed in the centre include registered nurses, care assistants, an activities co-coordinator, maintenance, laundry, housekeeping and catering staff.

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
Wednesday 27 November 2024	10:20hrs to 18:50hrs	Niall Whelton	Lead
Wednesday 27 November 2024	10:20hrs to 18:50hrs	Brid McGoldrick	Support

What residents told us and what inspectors observed

This was an unannounced one day risk inspection to monitor compliance with the regulations made under the Health Act 2007 (as amended) and to inform decision making regarding the renewal of the registration of the designated centre. The inspectors were met by the person in charge, who facilitated the inspection. The inspection included a focused review of the premises, fire precautions and infection control. The centre is registered for 30 residents, with 24 residents living in the centre on the day of inspection.

During the inspection, the inspectors met with residents, staff and visitors. The inspectors saw kind interactions between staff and residents. Staff greeted residents by name and were seen laughing and singing with the residents. Most residents were in the main open plan sitting and dining room during the day; some remained in their bedroom by their own choice. The inspectors had the opportunity to observe the dining experience; nine residents ate their meal from a bed table sitting in an armchair. Tables were not set to promote a person centred dining experience; residents had to ask for condiments as they were not placed on the table. Meals came to the table with sauce already poured on the food, which removed the residents choice about how to have their meal.

St. Teresa's Nursing Home is a designated centre for older people and comprises part of a large three storey multi-occupancy building. It is located in Cashel town and is close to amenities such as shops, a library and the adjacent church. The centre is registered for 30 residents, with 24 residents living in the centre on the day of inspection.

There was a coded lock on the external door and the inner door between the stairs and entrance hall. Inspectors were informed that there were no residents with access to the code. A risk assessment was required for each resident to determine if they could safely use the use the code lock.

The extent of the designated centre is laid out over three floors. Resident's bedroom accommodation was at first and second floor, all communal space, staff accommodation and most ancillary facilities were located at ground floor. There was a sluice room on the first and second floor, with a bedpan washer in the first floor sluice room. Some areas of the centre were not heated, one resident complained of the cold.

The entrance to the centre led through a stairway and subsequent entrance hall, off which the communal space for residents was accessed. To the left, there was a sitting room, small library and conservatory; straight ahead led to the main residents' communal room. This comprised of an open plan sitting and dining room, which was where most activities and dining took place and was where residents spent most of their time.. Owing to the lack of a nurse station at ground floor, the nurse occupied an area of the communal room for a desk to write up their notes. It

also served as a storage area for residents records. Resident records were stored in an unlocked cabinet in the corner of the dining area. An immediate action was issued to secure the cabinet with resident files to ensure that personal identifiable information was secure. As there was no treatment room/medication room ,the medication trolley was locked to a wall in the corner of the sitting room.

The open plan sitting and dining room was the route to the remainder of the ground floor which included the kitchen, laundry, staff room toilets and storage areas. There was a passenger lift to the upper floors from the dining area, and a further platform lift which opened directly from the rear stairway enclosure. During previous inspections, one lift was not operational; the inspectors found that both lifts were operational on this inspection.

From the entrance hallway, there was a door to the right into the adjacent part of the building, another building, which was beyond the registered footprint of the designated centre. The person in charge and clinical nurse manager were observed to use this space during the day and retrieved staff files from this room. The fire door into this room was observed to be left open on numerous occasions during the day which could pose a risk if there was a fire emergency in the centre or the building next door.

The smoking area for residents was in the escape stairway, and residents used this space frequently during the day. Residents either used their own chair, or a chair provided in the smoking area; this was causing an obstruction for the means of escape as this was one of the escape routes from the main open plan dining and sitting room. The under croft of the stairs was also part of the smoking area and this did not have guarding where the height of the underside of the stairs may cause a head injury. It was noted by inspectors throughout the inspection that the odour from the smoking area was evident in the areas surrounding the stairway including the sitting room. Staff and residents circulated through the smoking area to reach the platform lift and access the outdoor space and staff facilities. The inspectors saw that the escape stairway had heat detection at ground floor level and not smoke detection to ensure early detection of fire. There was also heat detection to the rear corridor and lobby to the kitchen.

There was a conservatory accessed through a sitting room. The exit in the conservatory was jammed and could not be opened when the lock was released. Furthermore, in this area, there were three opening sash windows integrated into the glazed areas; each of these were fixed shut with a restrictor unit. The window in the library was sealed with paint so these areas were not adequately ventilated.

The inspectors tested a sample of call bells. The call bell in the smoking area and two toilets each displayed as toilet on the call bell panel which may cause confusion in the event of a fire. The display panel was located in the kitchen and front entrance hall; there was none in the main day space where staff were mostly located, which may result in delayed response to the call bell.

Externally, there is outdoor space available for residents, accessed through the door to the rear of the centre. The inspectors observed a number of risks, such as

machinery and loose stone and timber which were not secured. There was also open access to the garden of an adjacent property. The garden area had pathways through mature planted areas, which created a pleasant garden feel. Some of the shrubs were encroaching onto pathways making it less accessible. Garden furniture was positioned as a barrier to one area between the centre and an attached chapel. This area was a risk as it had uneven ground creating a risk of trips and falls. To the front of the centre, there was parking for staff and limited parking for visitors. The front area was shared with the adjacent occupancy.

Inspectors observed that the décor in some parts of the building had not been updated, the lighting was low in a number of areas and light switches for resident bedrooms were located on the wall outside their room. Areas of the centre were carpeted including the conservatory and sitting room to the front of the building, and there was no steam cleaning schedule available to ensure it remained clean.

Inspectors observed that there were limited clinical hand hygiene facilities available for staff use. Additional alcohol dispensers or individual bottles of alcohol hand gel were required to ensure alcohol hand gel was readily available at the point of care. There were no towels provided for residents to carry out hand hygiene in the single rooms. A number of shared bathrooms did not have paper towels dispensers to allow residents to dry their hands to support good personal hygiene practices.

The quality of the bed linen was poor and many pillows, duvets and small number of mattress required to be discarded as they were worn and could not be effectively cleaned.

Improvements were required in storage of equipment. For example, a cleaning trolley and was stored in a room containing clinical equipment and supplies which posed a risk of cross infection. These and other matters relating to the clinical oversight and management of infection prevention and control are discussed under regulation 27.

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

Capacity and capability

The findings from this inspection demonstrated that the provider had failed to address the deficits in governance and management identified on previous inspections. The provider did not take the necessary measures to ensure that the service was safe, appropriate, consistent and effectively monitored.

Poor compliance with the regulations and inadequate provider responses to the previous two inspections in February and August 2024 prompted this inspection.

The registered provider for St. Teresa's Nursing Home was Cashel Care Limited. The company is made up of two directors. There was no director of Cashel Care Limited available to respond to the risks identified on the inspection, therefore an urgent compliance plan was issued to the registered provider, for the following:

- **Regulation 23, Governance and Management**; inadequate staffing levels and resources to manage infection control and fire safety risks
- **Regulation 27, Infection Control**; the centre had not been deep cleaned following an outbreak of a contagious skin condition, defective pillows and mattresses and laundry arrangements posed a risk of cross contamination
- **Regulation 28, Fire Precautions**; inadequate arrangements to ensure the safe evacuation of all residents from upper floors, inappropriate storage arrangements in an electrical cupboard and the arrangements for residents who smoke.

The inspectors followed up on actions taken by the provider to address regulatory non-compliance identified on previous inspections in February and August 2024.

Owing to the absence of a person in charge at previous inspections, a restrictive condition was applied to the registration of the centre, ceasing admissions. At this inspection a person in charge had commenced working in the centre three weeks prior; the condition was still in place as not all of the requisite information had been submitted for assessment. The provider was adhering to the condition and no new admissions had been made to the centre.

At this inspection, there was little progress made to address deficits to the premises and there was further non-compliance identified. Furthermore, risks to residents associated with poor infection control practice, fire safety risks and lack of oversight by the governance structure, meant that action was required to ensure the service was safe.

The office used by the person in charge and clinical nurse manager was not within the registered footprint of the centre and was within an adjoining building. Staff files were stored in this area, which had open access from the adjacent building undermining the privacy of personal information and the security of the centre. Residents files were stored within an unlocked cabinet in the main day space and were not secured from staff, residents, visitors and contractors entering the centre. Schedule 2, 3 and 4 records were not kept in a manner as to be safe and accessible in line with the requirements of regulation 21 Records.

There were not clear lines of accountability and responsibility in relation to governance and management of the centre; neither director of the company was available on the day of inspection. The person in charge was communicating with a third party who was not a director of Cashel Care Limited. Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre

rested with the assistant director of nursing (ADON), however due to a shortage of staff, the ADON was working the night duty roster to fill the gap in nursing shifts.

Significant and sustained clinical oversight was required to ensure that:

- hand hygiene facilities are provided in line with best practice and national guidelines
- arrangements are in place for the cleaning and disinfection of the facility in line with legislation and best practice guidance
- staff undertaking decontamination processes have the necessary training to do so
- clear information is recorded in residents' care plan outlining the treatment given and actions to prevent a re-occurrence of the contagious skin condition
- arrangements are in place for linen and laundry management including handling and segregation of clean and used linen, washing and storage in line with best practice
- arrangements are in place for disposal of waste and to ensure that the chemical bin is locked
- all management and staff receive additional training in infection prevention and control practices that is specific to their role and responsibilities, that incorporates combination of formal teaching, self- directed learning and assessment of practical skills.

Four residents were treated for a contagious skin condition on 30th October 2024; a previous outbreak of the same condition had occurred in November 2023. Inspectors were concerned that the same two bedrooms were impacted for both outbreaks. Inspectors found that pillows, duvets and a small number of mattress were torn and could not be effectively cleaned. Furthermore, on reviewing rosters, there was a reduction in staff assigned for cleaning duty. The provider committed to returning the roster to what it had been before the outbreak. The inspectors judged that the hours for cleaning duty prior to staff reduction, were not sufficient to ensure this three storey building could be adequately cleaned, as detailed under regulation 23; Governance and Management.

Registration Regulation 4: Application for registration or renewal of registration

The premises as it was operated was not configured to align with the statement of purpose and floor plans for which it was registered:

- an office area being used for the running of the designated centre, was not shown on the registered floor plans
- the platform lift was not shown
- some doors were missing and others shown incorrectly in some areas

The statement of purpose, did not include the whole time equivalent for staff.

Judgment: Substantially compliant

Regulation 15: Staffing

The provider had failed to ensure that there were sufficient staffing levels in the centre to meet the assessed needs of the residents, or for the size and layout of the centre.

- vacant shifts in the nursing roster resulted in management staff being redirected from their management and supervisory role to deliver direct care to the residents. This impacted on overall supervision of staff, and the supervision of the quality of care provided to residents. The staffing provided was not in line with the registered statement of purpose
- a vacant shift in the catering/kitchen staff resulted in health care staff being redeployed to assist in the kitchen for part of their hours reducing the number of hours available to provide direct care to residents. The last meal provided was at 16:30, and while there was provision for a tea trolley later in the evening, this resulted in long period of time between meals; this required review
- there was insufficient household staff provided. This impacted on the quality of environmental hygiene observed on the day of inspection
- there was insufficient staff provided on night duty to safely evacuate residents based on their assessed needs.

Judgment: Not compliant

Regulation 16: Training and staff development

Staff were not appropriately supervised, this was evidenced by poor practices in respect of infection prevention and control and use of equipment for manual handling which was not in line with evidenced based practice.

This is a repeated non compliance.

Judgment: Not compliant

Regulation 21: Records

A review of the record management systems in the centre found that records were not managed in line with regulatory requirements. For example;

records were not being securely stored in line with the regulations;

- residents files were stored within an unlocked cabinet in the main day room. These contained personal information and were not secured from unauthorised access
- staff files stored in an area that was not within the registered footprint of the designated centre. The inspector observed the retrieval of staff files from the unregistered and unsecured area
- the staff roster contained first names only. There were numerous markings on the roster which made it difficult to determine if the roster was actually a record of the hours worked
- care records were stored in multiple folders making it difficult to track resident weights, and vital observations such as temperature, pulse, respiration and oxygenation. As a result it was difficult to access the latest resident information.This is a repeated non compliance.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured the centre had sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose: this was evidenced by:

- reduced staffing from previous levels; insufficient cleaning, catering, nursing and health care staff.

The registered provider failed to ensure there was an effective organisational structure, with clear lines of accountability and responsibility in place. The organisational structure, as described in the centre's statement of purpose was not effective;

- there was no director of the provider, Cashel Care Limited, available to respond to significant findings of the inspection, nor was it clear who was deputising for the registered provider
- not all requisite information in relation to the newly appointed person in charge, as required under the regulations had been received by the Chief Inspector, prior to the inspection.

The inadequate resources and the poorly defined organisational structure impacted on the quality of the management systems in place to ensure that the service was safe and appropriately monitored. Examples included;

- poor supervision and oversight of cleaning procedures. Areas of the centre were not clean, for example, the catering kitchen and the laundry. There had been a reduction in cleaning hours in the centre; for example, there was one

cleaner on duty for eight hours on both Saturday and Sunday to cover three floors
- there was inadequate oversight of fire precautions and arrangements for reviewing fire precautions. The inspectors identified risk for two residents. Assurance was required that all residents evacuation needs have been reviewed and that suitable and safe evacuation is in place for all residents
- poor risk management systems did not ensure effective oversight of the risk of fire. For example, the smoking area was not suitable as detailed under regulation 28
- the office used by the person in charge and clinical nurse manager was not within the registered footprint of the centre and was within an adjoining building. Staff files were stored in this area
- failure to replace equipment when effective cleaning could not be achieved, for example; defective pillows, duvets and mattresses
- poor oversight of care and failure to ensure safe practices in respect of moving and handling were carried out. Equipment used was not in line with evidenced based practice
- the quality of the dining service experience required review to ensure each residents' dignity is upheld
- poor oversight of maintenance as evidenced by a defective exit door in the conservatory preventing evacuation and also by failure to ensure that there was adequate heating throughout the building. An immediate action was issued to address the defective exit and to have the heating restored in some areas
- poor oversight of care planning in respect of infection prevention and control
- repeated non compliance's were in found in regulations 15 Staffing, 17 Premises, 23 Governance and Management, 27 Infection Control, 28 Fire Precautions and 9 Residents' Rights.

An urgent action plan was issued following the inspection.

Judgment: Not compliant

Quality and safety

Overall significant improvements were required to meet the assessed needs of the residents and to promote their rights.

The provider continued to manage the ongoing risk of a contagious skin condition outbreak. Four residents were affected in this outbreak; the centre had experienced a previous outbreak of the same contagious skin condition in 2023. The findings of this inspection did not support that appropriate and effective action had been taken to prevent a re-occurrence of this contagious skin condition.

Inspectors identified examples of poor practice in the prevention and control of infection, for example; the general environment was not clean and well maintained. Some equipment for use by residents was not clean; an immediate action was issued to have soiled toilet seats cleaned in two resident communal toilets. The cleaning checklist reviewed indicated that these toilets were cleaned once a day which was not sufficient to ensure good hygiene standards. Laundry and linen was not segregated in line with best practice as the laundry facility was not laid out to support this. Access to the sink in the laundry could not be achieved due to the location of the laundry equipment.

Areas of the centre were cold; an immediate action was required to ensure that the heating system functioned appropriately. There was no documentary evidence of checks of the heating system being carried out.

The configuration of the centre, resulted in the main communal space being a circulation route through the building. Furthermore, in order to gain access to the outdoor space or one of the lifts, residents were required to circulate through the smoking area in the stairway.

All bedroom accommodation was located on the upper two levels. While each floor was subdivided into two fire compartments, assurance was required regarding the effectiveness of the fire compartment boundaries, in particular the attic above the second floor. There was an adequately sized escape stairs at each side of the building. While the overall layout supported adequate means of escape, the layout of individual bedrooms required review to ensure adequate space was available in the room for the assessed mode of evacuation. Further assurance was required regarding the evacuation of two residents; an urgent compliance plan was issued in this regard.

Regulation 12: Personal possessions

There was inadequate space provided for residents to store their personal belongings and to maintain their clothing. The wardrobe space provided was limited, for example; to hang an outdoor coat or to store their shoes.

Inspectors found that access to wardrobes and chest of drawers in the shared rooms was impeded as they were situated in one of residents space. If personal care was being delivered or the residents screens were closed residents would be unable to access their clothing or belongings.

This is a repeated finding.

Judgment: Not compliant

Regulation 17: Premises

The provider had failed to maintain the premises in a satisfactory state of repair. Actions were required to ensure compliance with Regulation 17: Premises and Schedule 6 of the regulations. For example;

- a number of twin bedrooms were not configured to provide adequate usable and private space for residents. There was inadequate space for the appropriate use of adaptive equipment and hoists, including when the bed is screened off; this was impacting resident rights to privacy. The configuration of beds in one room meant that the end of one bed was very close to the head of another. In another twin room, the privacy curtain was positioned across the bed
- there was an extension cord in one room, which stretched across in front of a wardrobe to a bedside locker, effectively obstructing access to the wardrobe
- not all parts of the centre were adequately lit, heated and ventilated. For example, the sitting room felt cold and not all thermostatic valves on radiators were working. An urgent compliance plan was issued to ensure the heating was adequate. The sitting room did not have a window to open air to ventilate the space. It opened onto a conservatory, the windows for which were locked shut. The lighting on bedroom corridors was not consistent and was operated by sensor units. The inspectors observed the lights turning on and off while in the corridor. The lighting levels were poor in corridors, the sitting room and conservatory
- the main dining/day room room was used for additional purposes such as activities, storage for files, nurses office and area to store medication trolley and as a circulation route through the building. This resulted in a reduction of usable communal space for residents. There was no nurses station for staff to carryout activities such as staff handover
- the smoking facility provided was not fit for purpose and placed both residents and staff at risk. As a result of the location of the smoking area, there was a malodour in the circulation corridors to the rear and also in the main dining/dayroom. The fire escape route through this area was impeded and in order to get to the platform lift or to the outside, residents and staff were required to circulate through this space
- the call bells provided in the smoking area and in two toilets all had the same annotation on the display. The call bell display at ground floor was either located in the kitchen or entrance hallway, and not in the vicinity of the nurse desk
- having regard to the dependency of the residents using the toilets in the area of the dining/sitting room; they were not suitable for those who may require a hoist
- handrails were only fitted to one side of the front stairway and not both sides as required under Schedule 6
- flooring was in need of repair in a number of areas. The floor covering on the staff room was in poor condition and could not be effectively cleaned. The stairs to the rear did not have a floor covering and was exposed concrete

- the storage arrangements in the centre were not adequate. Staff files were being kept in a non-registered area of the building. Resident files were within an unlocked cabinet in the dining room
- the external grounds were not safe or secure; there was equipment and piles of stone and timber in the external area. There was no clear boundary between the residents' outside space and the garden of an adjacent property. There was a a clinical bin which was not securely locked and was located adjacent to the generator.

This is a repeated non compliance.

Judgment: Not compliant

Regulation 27: Infection control

Under this regulation, immediate action was required by the provider to address urgent risks; Some equipment for use by residents was not clean; there were two soiled toilet seats in residents' communal toilets.

The manner in which the provider responded to the risks did provide assurance that the risk was adequately addressed. The person in charge arranged for the equipment to be immediately cleaned.

The registered provider had not ensured that procedures consistent with the National standards for Infection Prevention and Control in Community Services (2018) published by the Authority and implemented by Staff.

Residents had been seen by their General Practitioner and had been prescribed treatment. The provider did not have a robust plan in place following a recent outbreak of a contagious skin infection. The resources for the provision of cleaning were reduced, impacting on the ability of staff to ensure the centre was clean and to prevent ongoing transmission. Following treatment of the condition, a full deep clean had not been undertaken. The inspectors found that a review had not been conducted of the arrangements for laundering residents clothes, and no review had taken place of items known to transmit this condition such as pillows, duvets and mattresses. From a sample of care plans viewed, they did not include detail on the infection control measures in place to prevent on going transmission of the condition and the information to guide staff on residents' care plans relating to infection control were not adequate. There was no documentary evidence that residents had received information to understand the condition. In addition, inspectors found other risks that did not support good infection prevention and control practices, for example; there were poor hand hygiene facilities and laundry facilities.

The environment was not managed in a way that minimised the risk of transmitting a healthcare-associated infection. This was evidenced by;

- the laundry area was not managed in a way that reduced the risk of cross contamination. Due to the size and layout, the infrastructure of the on site laundry did not support the functional separation of the clean and dirty phases of the laundering process. Clean laundry was observed on top of the washing machine. The arrangements for laundry did not cater for the size of the centre and the amount of laundry to be completed. In addition there was insufficient space for the sorting of, drying and the storage of laundry
- there was no clean utility or treatment room for the storage and preparation of medications, clean and sterile supplies such as needles, syringes and intravenous fluids
- the sluice rooms did not support effective infection prevention and control; there there were two sluice rooms available, only one of which had a bedpan washer. The sluice room second floor did not have a bed pan washer. Staff were required to dispose of waste in the one on the first floor which presented a risk of spillage and cross contamination. There was a toilet and an attachment with a shower head in both sluicing facilities which presented a risk of cross contamination
- there was no separate storage space for the cleaning equipment for the for the catering service
- some surfaces and flooring was worn and poorly maintained within a small number of rooms and as such did not facilitate effective cleaning
- the chemical waste storage bin was unlocked
- paper towel dispensers were not functioning and there were no paper towels in some of the shared bathrooms. There were no hand towels for residents use in single rooms. This did not support good hand hygiene practice by either staff or residents
- inspectors observed chairs that had worn fabric and were not on a steam cleaning schedule.

Equipment was not not consistently decontaminated and maintained to minimise the risk of transmitting a healthcare-associated infection. For example:

- staff demonstrated a poor knowledge of the centre's cleaning procedure, and appropriate hand hygiene practices, to minimise the risk of cross infection
- equipment used for cleaning was not not clean, effective cleaning and decontamination is compromised if cleaning equipment is not clean
- cleaning equipment was stored within a general purpose store room. This posed a risk of cross-contamination
- the kitchen was not clean. Records showed equipment such as ovens had not been cleaned in a month. There was one staff member working in the kitchen who was responsible for all the catering needs of residents
- poor infection control practices were observed in relation to cleaning equipment; for example, unclean dustpans and brushes were used throughout the centre.

An urgent action plan was issued following the inspection.

The findings identified a repeated failure by the provider to establish a robust infection prevention and control monitoring system including a robust environmental auditing system.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspectors were not assured that the registered provider had taken all reasonable actions to ensure that residents were appropriately protected from the risk of fire. Under this regulation, immediate action was required by the provider to address urgent risks;

- the staffing resource at night time did not align with the providers assessed resource required to ensure safe evacuation
- an exit from the conservatory was damaged and not openable
- there was inappropriate combustible storage within the electrical cupboard, increasing the risk of fire.

The manner in which the provider responded to the risks did provide assurance that the risks were adequately addressed. The person in charge arranged for an additional staff resource at night time, arranged for an electrician to review the damaged exit lock and arranged for the combustible storage to be removed

Improvements were required by the provider to ensure adequate precautions against the risk of fire, reviewing fire precautions, and ensuring fire prevention practices were adhered to, for example:

- the arrangements for residents who smoke created a risk in the centre, in relation to residents safety, fire detection and means of escape
- the risk to the designated centre, from an adjoining premises had not been risk assessed; there was unsecured access to the designated centre from the adjoining building
- the utility shut off for the gas supply in the laundry room was not accessible; the one in the kitchen was not fully accessible and was at risk of impact from the leg of a stainless steel counter unit which was not fixed in place; this created a risk of gas leakage if impacted.
- the inspectors observed a number of extension cords in use, this is poor practice and increases the risk of fire
- the fire door to the sitting room was propped open with a weight
- the door to the adjoining building was observed to be left open on numerous occasions during the inspection
- there was a number of bathrooms where the cover to the light fitting was missing; this created a risk of moisture to the light fitting

- there was a mobility scooter left on charge in the escape stairway, introducing a risk of fire to the escape stairway

Action was required to ensure adequate containment and detection of fire, for example;

- assurance is required regarding fire containment and detection to ensure risks to the designated centre from the adjoining building is managed
- fire compartments; clarity was required regarding the fire compartments in the building. There was a door to an adjoining area that was not registered. Assurance that the adjoining building is separated from the designated centre by effective fire compartment boundaries
- assurance was required regarding the effectiveness of the fire compartment boundaries, in particular the attic above the second floor
- fire containment around the electrical cabinet in the food store required action. There were holes observed in the wall at two locations breaching the fire rated walls
- there was heat detection in a number of areas where smoke detection would be required, for example the corridor to the laundry, the lobby between the kitchen and escape corridor and the ground floor of the rear escape stairs
- there was no fire detection in the conservatory or laundry storage enclosure
- there was a lack of clarity regarding the category of, and coverage provided by, the fire detection and alarm system. The service records available indicated it to be an L2/L3 type system; nursing home use requires an L1 fire detection and alarm system, which relates to the areas covered by fire detection

Some actions were required to ensure adequate means of escape, for example:

- the smoking area located in the stairs resulted in obstruction of the means of escape and reduced fire detection; heat detectors were used at ground floor, and not smoke detection as required
- the conservatory extended across the window to the sitting room and the window to the escape stairs. In the absence of fire containment to the conservatory from these rooms, a pathway for fire was created which may impact the front escape stairway
- some areas of the external escape routes did not have adequate coverage of emergency lighting to ensure a safe escape to the assembly points
- the means for opening the exit from the conservatory required review. The manual door release had a cover on it, relying on staff to know the code. Not all staff knew the code to unlock the door.

The arrangements for maintaining fire equipment were not adequate:

- the service records for the emergency lighting had the incorrect standard referenced
- the periodic inspection report for the electrical installation was last completed in 2018 and was out of date

- there were some observed deficits to fire doors which required action, for example; some were warped, gaps to the sides of doors and some smoke seals were painted over, reducing the effectiveness of the smoke seal
- there was no record to show that the gas installation had been inspected and tested to ensure the system was correctly maintained and safe

In terms of evacuation, further assurances were required from the provider to ensure there was sufficient resources available to ensure the safe evacuation of all residents in the centre. The provider had not made adequate arrangements to safely evacuate all residents from the upper floors. In particular, the evacuation requirements for two residents at second floor were not adequate as identified to senior staff during the inspection. There were inconsistencies between care plans and Personal emergency evacuation plans (PEEPs). For example a care plan for a resident indicated the use of a hoist during evacuation, which differed from the PEEP.

From conversations with staff and a review of the content of training, the arrangements for staff of the designated centre to receive suitable training in fire safety were not adequate. Staff spoken with were not confident and gave mixed responses when relaying the evacuation procedures to inspectors. Poor practice was relayed to inspectors which included staff raising the height of a bed, so that a mattress secured by an evacuation ski sheet could be evacuated beneath the bed. This resulted in risk of injury to both the resident and staff.

An urgent action plan was issued following the inspection.

Judgment: Not compliant

Regulation 9: Residents' rights

A number of actions were required to uphold residents' right to privacy and dignity. This was evidenced by:

- residents in some twin rooms did not have access to a chair by their bedside if they wanted to sit beside their bed. They would be required to request for a staff to locate and bring a chair if needed
- the privacy curtain was positioned across a bed in a twin bedroom on the second floor. This layout did not facilitate this resident to undertake personal activities in private
- the light switch for residents' bedrooms were located on the wall outside the bedroom in the corridor. This meant that a resident would be required to come out of their room to switch on or off the light, impacting the resident’s privacy and dignity
- there was insufficient space for residents to carry out activities in private in their private bedspace

- residents did not have access to the code for the front door, there was no risk assessment to determine if there were residents who could, and whose preference it was, to independently exit the building
- there was evidence of institutionalised practice such as a specific day in the week for residents to have a 'a shower day', Monday was the designated shower day for the centre.

The arrangements for residents to dine did not fully uphold their rights. Not all residents were provided with a dining table to eat their meals; nine residents were observed to eat their meal from a bed table in the dining/dayroom from an armchair. Furthermore, there were no condiments provided, instead residents were required to request these from staff for them to be provided. The last meal was distributed at 16:30 hours. A review of the meal times is required, with input from a suitably qualified nutritionist to ensure residents nutritional needs are being met.

The quality of bed linen provided was poor. Residents did not have access to hand towels in bathrooms to perform effective hand hygiene. There was limited activities provided due to a shortage of staff.

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	
Registration Regulation 4: Application for registration or renewal of registration	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St Teresa's Nursing Home OSV-0000293

Inspection ID: MON-0045369

Date of inspection: 27/11/2024

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Registration Regulation 4: Application for registration or renewal of registration</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Registration Regulation 4: Application for registration or renewal of registration:
• Registered Provider reviewed the office area, it will not in the future be used for the running of the designated centre, only for his personal use.
• The platform lift and doors are now on the floorplan
• Statement of purpose has been reviewed, whole time equivalent staff now included.</td></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• PIC in post since the 17.02.2025 and supernumerary 5 days a week. ADON and CNM combined have minimum 24 hours per week supernumerary.
• Additional Kitchen staff have been appointed within our current staffing levels, and we are advertising to recruit additional staff required for full occupancy levels.
• Mealtimes have been reviewed and updated following a residents meeting: Residents requested tea at 4.30pm. At 6pm and 8pm residents are receiving additional snacks (sandwiches and biscuits and drinks).
• Tea`s and snacks available throughout the day and nighttime at resident's request.
• Sufficient household staff rostered.
• Increased staffing level at nighttime to safely evacuate residents based on their assessed needs. There is now 2 HCAs and 1 nurse rostered for night duty.</td></tr>
</table>

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• All staff have completed AMRIC course on HSEland.
• Infection Prevention and Control training has also taken place on site and staff are being supervised daily by the management team.
• Training is ongoing and moving and handling training has been booked for 24th March this year.
• PIC in post and is reviewing training matrix and working alongside ADON to ensure all training is completed as required.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• Residents' files kept in the locked cabinet in the main day room and secured from unauthorised access.
• Staff files kept in the locked cabinet in the conservatory.
• Staff roster reviewed and contains full names of each staff member. The printed roster is the live roster and management update it daily if staff shifts change.
• Care records of observations for residents are placed in their files, section 2 for vital signs and section 6 for weights and BMI.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• An additional 24 hours added HCA roster, Kitchen assistants daily rostered and an additional housekeeper rostered.
• Management staff reviewed the PEEP and additional staff added on the roster and the evacuation requirements for two residents at second floor reviewed and changed as per PEEP .

• Plan to implement a new smoking area in the next 6 months as building work may be required.
• Registered Provider reviewed and the office area won`t be used for the running of the designated centre .
• Any pillows , duvets and mattress that are non compliant are replaced.
• Practical manual handling booked for February .
• Some of the residents prefer to use the bedside table in the sitting room for meals ,consent signed by residents or family as applicable.
• Exit in the conservatory has been repaired.
• Heating system reviewed by the relevant personnel and serviced as needed
• All nurses have been informed in respect of care planning.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• The management team has reviewed storage and changed the position of the wardrobes and beds.
• We are currently reviewing old unwanted clothes with residents and their families to optimize storage capacity.
• Residents have locked drawers available for personal belongings in their bedrooms and have a key for their own drawers.
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Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Twin bedroom reviewed and position of the beds changed and curtain rails repositioned.
• Extension cord is removed from room.
• Heating system reviewed by a plumber to ensure the heating is adequate and thermostatic valves on radiators were repaired and are now in working order.
• We open the windows and door as needed in the conservatory to ventilate the sitting room and shut the front main gate to ensure residents safety within the outside grounds of the building.

• Lighting has been increased on the corridor brighter lights have been in put in place in the dayroom, sitting room and conservatory.
• We have adequate communal spaces for residents including the dayroom/ dining room, front sitting room, conservatory and library where the residents complete activities, meet family members and have private time as required.
• Residents can smoke in the garden when the weather permits, and in the meantime two residents at a time can smoke in the concrete back stairwell area as it does not pose a fire risk. Plan to implement a new smoking area in the next 6 months.
• Staff handovers are now being completed at the nurse's station on the first or second floor when the day room is occupied by residents.
• Plan to change the call bell display near to the nurse desk. Call bell supplier contacted and waiting for the reply. We also asked for the annotation on the display for the smoking area and residents toilet.
• Residents who require the use of a hoist use their own toilet in their bedroom with the assistance of staff
• Double handrail for front stairwell have been put in place.
• Floor covering on the staff room and store room has been replaced. We are currently reviewing appropriate flooring for rear stairs.
• Staff and resident's files are kept in the locked cabinet in registered parts of the building.
• External areas are currently being made safe and secure for residents.
• Garden furniture has been put in place to rectify the boundary between the nursing home grounds and the adjacent property.
Clinical bin is now securely locked and kept it away from the generator.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Both toilet seats replaced and all staff are reminded to ensure toilets are cleaned when caring for residents personal needs.
• All staff are aware of the National Standards for Infection Prevention and Control in the community setting following IPC training and management are ensuring these stand-ards are implemented through supervision.
• Post outbreak review will be completed 27th of February with PIC and learning out-comes will be identified and implemented for future outbreaks to ensure robust plans are in place.
• PIC is booking care plan training for all nursing staff to ensure appropriate person cen-tred care plans in place for all residents and this will include contagious disease care plans.

• We have segregated clean and dirty linen so that there is no risk of cross contamination.
• We Developed a flow for used laundry to enter, be laundered and clean laundry leaves the room.
• In our center we have 2 nurses’ stations on each floor which are dedicated for storage of medications, needles, sterile supplies, and dressing materials and both nurses stations have sinks available.
• Dispose of waste in the first floor: to prevent spillage and cross contamination we are covering commodes and urinals with lids and on second floor we are using the commode liners. Toilets and shower head have been removed from both sluice rooms.
• In the Chemical room the cleaning equipment for the catering service kept separately.
• The surfaces and floorings have been renewed.
• Chemical waste storage bin is now locked.
• An additional 12 Hand Towel dispensers have been fitted on Wednesday 4th of December 2024 and additional Hand sanitisers added as per IPC guidelines
• Deep cleaning details company completed a deep clean of the nursing home on Tuesday 3rd of December 2024
• Cleaning schedule reviewed and weekly steam cleaning in place. Management staff are signing off schedules weekly once completed.
• All Staff are trained of the importance of hand hygiene and cleaning procedures. Management team are completing daily checks regarding IPC on their walk arounds.
• Management staff check cleaning equipment is clean on daily walk arounds the nursing home
• Cleaning equipment is stored in the second floor.
• Pillows and mattresses have been replaced as needed
• Kitchen Cleaning schedule reviewed and additional staff allocated to kitchen.
• Updated daily/weekly cleaning schedule for designated centre.
• PIC has increased IPC audit from quarterly to monthly for this quarter to ensure standards are improved.
• All staff have been reminded of the importance of IPC guidelines and ensure cleaning schedules are completed to the highest standards as per IPC guidelines

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• At present we have 4 residents who are smoking, in next 6 months will implement a new smoking area outside. Management have arranged for a fire detector in the smoking area.
• The gas supply in the laundry and kitchen is reviewed and made fully accessible.
• Risk assessment for the unsecured access from the designated centre to the adjoining premises completed and only the proprietor has access to this area.
• Extensions cords are removed.
• All staff informed to keep the fire doors closed.
• Adjoining building door is closed all the time.

• Cover to the light fitting reviewed and replaced in the bathrooms.
• Mobility scooter removed from under the escape stairway.
• Fire safety company have been contacted to review the risks of fire containment and detection from the nursing home to the adjoining building.
• There is a fire door in place between the designated centre and adjoining building.
• Fire doors are in place in the compartment where the attic is above the second floor.
• In the food store, electrical cabinet holes are closed.
• Reviewed smoke detectors and fire doors gaps will change as soon as possible.
• More fire detectors will be in place ASAP and fire safety company have been contacted to complete.
• Fire company contacted , reviewed the fire detection and alarm system and has been certified on L1 .
• More smoke detectors will be in place ASAP.
• Heat detectors will be replaced with fire detectors in the smoking area.
• The ground floor window between the front escape stairs and conservatory is blocked and plastered to protect this stairway from the progress of fire.
• More Emergency Lights have been fitted on the external escape routes.
• We have replaced with emergency door release in the conservatory.
• Emergency lights test certificate updated including the new standard.
• Periodic Inspection Report for an Electrical Installation updated.
• Fire Company for fire alarm service has been contacted regarding fire doors and will review and fix issues around warped doors and gaps.
• The Personal Evacuation Plans or PEEP'S have been updated.
• The provider has employed the services of a gas supplier regarding the gas installation record.
• Fire Drills are completed every month on both shifts and allocated residents as per their dependency level.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Reviewed the twin rooms and placed the chair in each room.
• The privacy curtain was reviewed and repositioned around each bed to facilitate residents personal activity.
• Reviewed and changed the position of the furniture.
• All the bedrooms have a bedside switch light in place.
• For private activities residents can use the front sitting room, conservatory, their bedroom or go out to the fully enclosed garden or out town with or without staff once safe to do so.
• If a resident wishes to go out, the nurse in charge will complete a risk assessment as

needed.

- There is only one resident in the nursing home that is able to go out alone and code for front door code offered to resident, but they declined as staff open the door.
- Management staff reviewed all the showers offered in the centre to our residents and we do not have a specific shower day, residents' choices are respected.
- Some of the residents prefers to use the bedside table in the sitting room as per their choice and this is reflected in their care plans.
- Replaced the condiments on each table for every meal.
- Residents prefers tea at 4.30 PM and there are happy with the meal times and they are subsequently offered additional snacks and drinks at 6pm and 8pm. The residents are also receiving additional snacks/sandwiches during the day and night at their request.
- An additional 12 Hand Towel dispensers are in place.
- There is now an activities coordinator on duty 5 days per week and we have advertised for an additional part time activities coordinator.

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
Registration Regulation 4 (1)	A person seeking to register or renew the registration of a designated centre for older people, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Substantially Compliant	Yellow	10/01/2025
Regulation 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Not Compliant	Orange	01/04/2025

Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	10/01/2025
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	10/01/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/04/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to	Not Compliant	Orange	30/06/2025

	the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.			
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	31/08/2025
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	10/01/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	10/01/2025
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Red	30/04/2025

Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Red	01/03/2025
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	Red	30/04/2025
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	Red	10/01/2025
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting	Not Compliant	Red	31/08/2025

	equipment, suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	10/01/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/08/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques	Not Compliant	Orange	10/01/2025

	and the procedures to be followed should the clothes of a resident catch fire.			
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	10/01/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/06/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Red	10/01/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in	Not Compliant	Orange	10/01/2025

	accordance with their interests and capacities.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	10/01/2025
Regulation 9(3)(c)(ii)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may communicate freely and in particular have access to radio, television, newspapers and other media.	Substantially Compliant	Yellow	10/01/2025