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:	Cahercalla Community Hospital & Hospice
Name of provider:	Cahercalla Community Hospital Company Limited By Guarantee
Address of centre:	Cahercalla Road, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	13 January 2022
Centre ID:	OSV-0000444
Fieldwork ID:	MON-0035102

About the designated centre

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

Cahercalla Community Hospital and Hospice is located on the outskirts of the town of Ennis. It provides care to long-term, respite, and convalescence residents and also has five designated hospice beds. The centre was originally opened as a hospital in 1951, and while there had been significant extensions and renovations since then, the overall the design and layout of the premises was largely reflective of a hospital from this period. The original building consists of a three storey units, Ground floor, St. Joseph's and Sacred Heart. An unused clinical unit beside the ground floor unit has recently been refurbished. This new unit consists of three twin rooms, two single rooms, a large day room and a large dining room. The centre also has a two storey building with two units, Garden wing ground floor and Garden wing first floor. The centre is registered to accommodate 112 residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	88

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 13 January 2022	10:00hrs to 17:30hrs	Una Fitzgerald	Lead
Thursday 13 January 2022	10:00hrs to 17:30hrs	Noel Sheehan	Support

What residents told us and what inspectors observed

Overall, the feedback from residents living in this centre was very positive. Residents said that they were satisfied with the care and service provided. Some residents stated that the staff were very kind and caring, that they were well looked after and they were happy living in the centre. When residents were asked about the staff, one resident stated "they never let me down". Residents spoken with were satisfied with the time it took to have their call-bells answered.

The inspectors arrived unannounced to the centre and were guided through the infection prevention and control measures necessary on entering the designated centre. These processes included hand hygiene, face covering, and temperature check. Residents spoken with were delighted that restrictions on visits had been eased in line with public health guidance. Several visitors were observed coming and going throughout the day. Residents confirmed that they could receive visitors in the privacy of their own bedrooms if they wished. Visitors spoken with informed inspectors that the staff were "very strict" on the health screening and this was a source of reassurance to them. Inspectors observed staff taking the time to show visitors how to apply the FFP2 surgical masks that provide added protection in the spread of the virus. These masks were freely available at the entrance and provided to all visitors.

The inspectors observed that the majority of residents chose what way to spend their day. Some residents were up and about and relaxing to music in the day rooms, some were reading the daily newspapers, while others were relaxing in their bedrooms. However, inspectors did note that the daily newspaper provided to residents in one of the communal room was outdated by a number of days.

Residents were aware that there has been, over the course of a number of months, a restructure to the nursing management in the centre. Residents knew who the director of nursing was. A resident satisfaction survey had recently been completed. During the last inspection, inspectors found that the timing of meals had been very early in the day and that meals were task driven and not a social engagement. The most recent residents' survey held on 4 and 6 January 2022 identified that the timing of the serving of meals continued to be a source of dissatisfaction for some residents. While some progress had been made, inspectors found that further action is required. This was discussed with the management team who were committed to addressing the dissatisfaction.

The activities schedule was displayed and included a variety of activities. Throughout the inspection, residents were observed taking part in and enjoying a number of group activities. There was a staff member allocated to the supervision of communal rooms. Staff were seen to encourage participation and stimulate conversation. The inspectors summarised from the answers to questions that the staff knew the residents' care needs. Activities staff are on duty seven days a week.

Capacity and capability

This inspection was an unannounced risk-based inspection completed in one day. The registered provider had submitted an application to remove condition 4 of its current registration and this was being reviewed. Condition 4 in place states that the provider shall address the regulatory non compliance as outlined in the compliance plan dated 1 August 2019 to the satisfaction of the Chief Inspector no later than 31 October 2019. The last inspection of the centre took place in September 2021 where non-compliance across multiple regulations was found. A meeting was held with the registered provider and representatives following the previous inspection as an escalation. On this inspection, inspectors followed up on the last inspection findings and found that significant progress had been made to bring the centre into compliance with the requirements of the regulations. The governance and management structures had been strengthened and were now in line with the centre's statement of purpose and function. In addition, the provider has increased the monitoring and auditing of the service which lead to improved oversight of the service provided to the residents. Notwithstanding the progress made, inspectors found one area relating to the availability of staff in the direct provision of care had not been fully addressed.

Cahercalla Community Hospital Company Limited By Guarantee is the registered provider of the centre. Mowlam Healthcare Services is participating in the management of the service and is operating the day-to-day running of the service. The governance and management structure in place had been sufficiently strengthened since the last inspection. The director of nursing was supported by an assistant director and both were working full-time in management roles. In addition, the person in charge was also supported by three full-time clinical nurse managers who were allocated supernumery 15 hours per week. This resulted in the centre having a supernumerary clinical nurse manager on duty seven days a week supporting oversight and governance.

To ensure the centre was operating in line with the regulations and standards, the provider had a number of oversight arrangements. The person in charge had implemented Mowlam's Auditing Management system (MAMS). The audit schedule covered a wide range of topics, including falls, restrictive practice, wound care, care plans and medication. Audits reviewed were seen to be thorough, and any actions that were needed to drive improvement were being progressed. The management team was working together to oversee residents' care and undertook reviews of the care and support being provided. There was evidence of good systems of communication that included monthly governance meetings with the provider and the management team, quality and safety meetings, staff meetings and daily handover and safety pauses. There was evidence that the management team discussed all clinical and operational matters on an ongoing basis. It was apparent that the registered provider and person in charge encouraged and were responsive to feedback about the service from residents and families.

Following the last inspection, the systems in place to ensure newly appointed staff were inducted to their roles had been strengthened. With the additional supernumerary nurse management hours in place staff supervision and mentoring had improved. The centre had an active recruitment campaign in place. Despite this, the centre continues to have a high level of staff turnover and this was resulting in days whereby staff shortages in the direct delivery of care were not replaced. Three activity staff were on duty on the day of inspection which is an increase since the previous inspection.

The management team was committed to providing ongoing training to staff. There was a training schedule in place and training was scheduled on an ongoing basis. The training matrix reviewed identified that staff had received mandatory training in safeguarding vulnerable adults from abuse, fire safety, people moving and handling, infection prevention and control, hand hygiene and the management of responsive behaviours.

There were systems in place to manage critical incidents and risk in the centre. Accidents and incidents in the centre were recorded, appropriate action was taken and they were followed up on and reviewed. There was evidence of quality improvement strategies and monitoring of the service resulting in continuous improvements in the quality of life and quality of care for the residents.

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

The application form for the removal of Condition 4 was submitted and the required registration fee had been paid.

Judgment: Compliant

Regulation 15: Staffing

The management team on the day of inspection confirmed that recruitment of staff was ongoing. Inspectors found that the current person in charge had sufficient numbers of staff available to deliver the care as per the assessed needs of the current number of residents on the day of inspection; however, despite efforts made, there continues to be a shortfall in the number of staff available to deliver the direct care. As a result of the ongoing staffing shortages, the negative impact was that:

- rosters evidenced that in one week there was a daily shortfall of healthcare assistants available varying from 12-24 hours a day meaning that shifts were not fully covered in some instances.

- while rosters were not impacted to the extent seen in the previous inspection, extra staffing capacity is still required to ensure availability when short notice or ad-hoc leave occurs.
- the centre continues to have a high level of staff turnover and this was resulting in days whereby staff shortages in the direct delivery of care were not replaced.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The centre's management was committed to providing ongoing training to staff. Training in infection prevention and control, including hand hygiene and the donning and doffing of PPE, was provided through Health Service Executive (HSE) online training. Records maintained of staff attendance at these training sessions indicated that a majority of staff had attended. The person in charge explained that all online training was followed up with in-house information sessions. The training matrix evidenced full compliance with mandatory training required by the regulations. Staff had received mandatory training in safeguarding vulnerable adults from abuse, fire safety, people moving and handling, infection prevention and control and hand hygiene.

The person in charge held responsibility for the ongoing supervision of staff. Interactions between staff and residents observed throughout the day were respectful and kind. Following the last inspection the management had put in place role-specific induction programmes for all staff. A record of the induction was held in each individual staff file. The induction programme was completed during the first four weeks of employment.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. Robust management systems were in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored. There were regular management meetings and audits of care provision and quality assurance initiatives.

Significant improvements in overall compliance with regulations had been

implemented since the previous inspection in September 2021; however, governance systems still required strengthening as actions to address issues identified on the previous inspection related to fire safety, infection control, staffing and residents' rights were not completed.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notifications to the Chief Inspector were submitted in accordance with time frames specified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspectors reviewed the complaints log. There was evidence that when a complaint is logged appropriate steps are taken as per the centre's policy. The documentation in place evidenced that the management engaged with the complainant to ensure that all reasonable measures were taken to ensure a satisfactory outcome. There was one open complaint on the day of inspection that was in process.

Judgment: Compliant

Regulation 21: Records

Records were stored securely and readily accessible. A review of a sample of personnel records indicated that the requirements of Schedule 2 of the regulations were met.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents felt safe and were supported and encouraged to have a good quality of life in this centre. Residents reported that they

felt the direct care and support they had received was of good quality. Notwithstanding the overall findings, improved oversight was required in infection prevention and control, the management of fire precautions and the overall maintenance of the premises to ensure residents were provided with a safe and quality service.

The inspectors reviewed residents' files. In the main, care plans were found to be individualised and person centred. The electronic documentation system in place was clearly laid out and the information was easily retrieved. Residents had access to medical and allied healthcare supports. Assessment and care plan updates were undertaken and outcomes discussed with residents and their representatives.

Each resident's needs were assessed on admission and at regular intervals thereafter. Staff used a variety of accredited assessment tools to complete an assessment of each resident's needs, including risk of falling, malnutrition, pressure related skin damage and mobility assessments. These assessments informed care plans to meet each resident's needs. The interventions needed to meet each resident's needs were described in person-centred terms to reflect their individual care preferences. Inspectors reviewed documentation on wound management and found that the clinical intervention management steps taken had resulted in the healing of wounds. Inspectors also reviewed the documentation in place specific to the management of pain. The records clearly identified where the pain was located, pain assessment were completed prior to and post the administration of pain medication. The care plans were person centred and guided the care.

The layout of the premises supports the needs of the residents and provided adequate indoor private and communal space. While some improvements had been made since the previous inspection, such as the removal of all damaged resident equipment and the purchase of new equipment, further monitoring on the cleanliness of equipment and the overall maintenance of the premises is required. For example, the corridor walls in multiple areas are in need of repair to chipped paintwork and damaged plaster. Regulation 27: Infection control is outlined below.

The inspectors reviewed the centre's records in respect of fire safety. Daily checks of means of escape were documented and escapes were observed to be unobstructed. Certificates for the fire alarm and emergency lighting tests were reviewed. Each resident had a personal evacuation plan in place and simulated fire evacuation drills had taken place. When walking the premises, inspectors observed that multiple fire doors were in need of attention to ensure that in the event of a fire the doors would close. In addition, inspectors requested certification for some of the fire doors as the glass panels in place did not have a visible stamp that the glass meets fire safety requirements.

Residents' rights were promoted in the centre and residents were encouraged to maximise their independence with support from staff. Residents were observed to be engaged in activities throughout the day. Residents were familiar with the activity schedule on display and could choose what activity they wanted to attend or could choose to remain in their bedroom and watch TV or chat with staff.

Regulation 11: Visits

Residents were supported to maintain personal relationships with family and friends. The centre was facilitating visiting in line with the current COVID-19 Health Protection Surveillance Centre (HPSC) guidance on visits to long-term residential care facilities. Visiting had resumed in the centre and relatives spoken with were very appreciative of the visiting arrangements in place.

Judgment: Compliant

Regulation 26: Risk management

The risk policy contained all of the requirements set out under Regulation 26(1). The local risk register was kept under review by the person in charge. The risk register identified risks and included the additional control measures in place to minimise the risk.

Judgment: Compliant

Regulation 27: Infection control

A number of issues which had the potential to impact on effective infection prevention and control measures were identified during the course of the inspection. This was evidenced by:

- A small number of staff were not wearing appropriate face masks as per the current guidance.
- Resident equipment that was stored away for use was not clean and ready for use with the next resident.
- The underside of a number of wall mounted soap and alcohol hand gel dispensers were stained and not effectively cleaned.
- Corridor walls in multiple areas are in need of repair to chipped paintwork and damaged plaster. Due to the damage, the surfaces cannot be effectively cleaned.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspectors released multiple fire compartment doors and observed that the door seals did not always meet. In addition, inspectors observed gaps between the door frame at the top and at floor level. For example, inspectors were able to place their hand under the door when closed. This meant that in the event of a fire the smoke would not be contained in the compartment. This is a repeated non-compliance from the previous inspection.

Inspectors observed that the glass panels in some of the fire doors. Inspectors requested for submission of a certification that the glass on these doors met fire safety requirements at the feedback meeting. One emergency light was not working on the Garden Wing first floor.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Each resident had an assessment completed on admission to identify their care needs using a variety of validated assessment tools. This included assessment of dependency needs, falls risk, nutritional risk and risk of impaired skin integrity. The inspectors reviewed a sample of resident files. In the main, care plans were found to be person-centred and included personal information required to deliver person centered care. Gaps identified were addressed on the day of inspection.

Judgment: Compliant

Regulation 6: Health care

The inspectors found that residents had access to appropriate medical and allied healthcare support to meet their needs. Residents had a choice of general practitioners (GP). Services such as tissue viability nurse specialists, speech and language therapy and dietetics were available when required. The inspector found that advice given was acted upon which resulted in good outcomes for residents.

Judgment: Compliant

Regulation 9: Residents' rights

A review of the times breakfast and the main dinner meals were served continued to be a source of dissatisfaction to some residents. While inspectors acknowledge that

a resident satisfaction survey had recently been completed, the results of the survey now require action.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 21: Records	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Cahercalla Community Hospital & Hospice OSV-0000444

Inspection ID: MON-0035102

Date of inspection: 13/01/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The PIC will monitor the rosters closely to ensure that planned rosters are implemented in practice. The Person in Charge (PIC), supported by an Assistant Director of Nursing (ADON) and Clinical Nurse Managers (CNMs), will produce and monitor the staff roster, always ensuring that an appropriate level skill-mix of staff are deployed, whose duties are allocated appropriately; that there is always a suitable ratio of clinical staff to residents to enable all care needs to be safely and effectively met; and that effective supervision, support and cohesive team working are integral to the culture of the hospital. • There is a robust recruitment plan in place to address identified staff vacancies. The PIC will continue to recruit staff into current vacant positions: 2 Staff Nurses and 8 HCA have recently been appointed. • In the event of unanticipated staff shortage, due to sickness leave for example, the PIC will review the roster to bridge the gap with existing nursing or HCA staff; if this is not possible, we will use agency staff to fill any vacant shifts. • The ADON and CNMs will supervise workflow and care practices to ensure that staff are facilitated to provide high quality, safe and effective care to all the residents in the hospital.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Fire safety: • The PIC will liaise with the Facilities Manager to ensure that a full review of all Fire	

Doors is completed, and to arrange for gaps in the fire doors to be repaired as required.

Infection control:
• The PIC will ensure that equipment has a cleaning record attached to it which staff will complete once equipment has been cleaned, this will indicate that equipment has been cleaned and is ready for use.
• Cleaning of all clinical equipment is scheduled on night shift and is monitored by the Charge nurse on duty.
• The PIC will ensure that staff have attended training in IPC and that they can demonstrate a sound knowledge of the requirement of cleaning of equipment.
• The PIC supported by the ADON/CNM'S will ensure daily monitoring of equipment for compliance in cleaning, ensuring that any equipment unfit for use will be replaced.
• The PIC will ensure the management and cleaning of equipment is discussed at the monthly IPC meeting/ weekly management meeting and daily safety pause meetings.
• The ADON and CNMs will supervise IPC practises to ensure that staff are providing a high standard of infection control.

Staffing:
• There is a robust recruitment plan in place to address identified staffing deficits.
• The roster is reviewed on an ongoing basis to ensure that staffing levels and skill mix are always sufficient to meet residents' assessed care needs and to provide required services.
• In the event of unanticipated staff shortage, due to sickness leave for example, the PIC will review the roster to bridge the gap with existing nursing, HCA or ancillary staff; if this is not possible, we will use agency staff to fill any vacant shifts.

Resident Rights:
• The nursing management team will be available and accessible to enhance communication and consultation with residents and families to ensure that care is being delivered in accordance with their identified needs/preferences as outlined in their care plan.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• The PIC supported by ADON and CNM's will ensure that staff follow guidance on correct use of face masks. This will be monitored during daily walk about and at handover/safety pause meetings.
• The PIC will ensure that equipment has a cleaning record attached to it which staff will complete once equipment has been cleaned. Any equipment deemed to be unfit for use for use will be de-commissioned and replaced.
• The PIC will ensure that all wall mounted soap and alcohol gel dispensers are clean and free from dried gel, these will be checked as part of daily surface cleaning.

• The PIC will ensure that a review of the maintenance programme will be undertaken to incorporate the management and the repair of any chipped or damaged surfaces.

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The PIC will ensure that a full review of all Fire Doors is completed and will ensure that seals are replaced as necessary. • The PIC will ensure that Certification of glass on fire doors is in place. • The PIC will ensure that the emergency lighting will be monitored and replaced where necessary.	
Regulation 9: Residents' rights	Substantially Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • The PIC will ensure that a review of breakfast and dinner times is undertaken, and changes will be made for those residents who wish to eat either earlier or later. Resident preferences will be clearly documented in their respective care plan and this preference will be communicated to all staff. • The PIC will ensure that an action plan is developed following the recent resident Survey, the results of which will be made available to all residents, families and staff.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/04/2022
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2022
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the	Substantially Compliant	Yellow	31/03/2022

	prevention and control of healthcare associated infections published by the Authority are implemented by staff.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2022
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	31/03/2022