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:	SignaCare Killerig
Name of provider:	Signacare Killerig Ltd
Address of centre:	Killerig, Carlow
Type of inspection:	Unannounced
Date of inspection:	03 April 2023
Centre ID:	OSV-0005454
Fieldwork ID:	MON-0038491

About the designated centre

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

SignaCare Killerig Nursing Home is situated a short driving distance from Tullow town in County Carlow. The centre provides accommodation for 45 residents. It caters for both male and female residents aged over 18 years of age. Residents are accommodated in 35 single bedrooms and 5 twin rooms, each with ensuite shower, toilet and wash basin facilities. Bedrooms are located on the first and second floor. The ground floor mostly consists of spacious communal areas and various services such as catering, laundry and treatment rooms. Care services provided at SignaCare Killerig include residential care, convalescence, respite and palliative care for residents. The provider employs a team of staff in the centre to meet residents' needs. This team consists of registered nurses, care assistants, an activity coordinator, maintenance, housekeeping and catering staff. According to their statement of purpose, value is placed on the uniqueness of each individual and the centre is guided by a commitment to excellence that ensures every resident will enjoy passionate and professional care. They aim to enhance the ability of residents to participate in and contribute to daily life. Facilitating residents' independence and choice in how they plan their daily lives. The centre aims to provide a person centred approach to care where staff will endeavour at all times to deliver quality care informed by best practice and complying with all relevant standards and legislation ensuring the residents are involved in all aspects of planning and decision making.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	41

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
Monday 3 April 2023	09:25hrs to 18:10hrs	Sinead Lynch	Lead
Monday 3 April 2023	09:25hrs to 18:10hrs	Deirdre O'Hara	Support

What residents told us and what inspectors observed

Throughout the inspection, the inspectors observed that there was adequate staff to meet the needs of the residents in a timely manner. Residents had their call bells answered promptly and residents told the inspectors that there were always staff available to support them.

Residents complimented the food and snacks provided to them. 'There is always a great choice' and 'they will make you up something when-ever you want'.

In the reception area there was a coffee dock provided for residents and their visitors. This had a coffee machine and comfortable seating for residents to relax in. One family was observed to be sitting back with their relative watching TV in a very homely relaxed fashion.

There was a large court yard off the dining room on the ground floor. This provided ample table and chairs for residents and their visitors to sit in. The court yard was surrounded by colourful trees and shrubbery. Residents told the inspectors that they loved sitting out there in the summer time as it was a 'perfect sun-trap'.

There were tables around the centre in all communal areas with jugs of drinks and bottled water available for residents. Residents in their rooms were provided with fresh drinks in the morning with some requesting juice while others requested bottles of water. Staff were very prompt in answering to residents call bells and assisting them when required.

Residents were observed enjoying a sing-along in the ground floor activities area. There were two activities staff in the centre that covered activities over a seven day period. Residents who spoke with the inspectors informed them that the activities are good and they really enjoyed the arts and crafts and the preparing for the upcoming Easter celebrations.

Residents were very complimentary in their feedback and expressed satisfaction about the facilities in the centre and the standard of hygiene in their bedrooms and communal areas. During this inspection, inspectors visited some residents' bedrooms, toilets and bathing facilities, communal and dining rooms as well as ancillary rooms such as the kitchen, dirty utilities, cleaners' rooms, store rooms, laundry and staff areas.

Overall, the general environment and residents' bedrooms, communal areas and toilets, bathrooms inspected appeared clean with few exceptions. For example, carpets in an equipment store and the activity room and flooring in one housekeeping room, the kitchen and physiotherapy were stained or damaged. Hoists were inappropriately stored and unclean in corridor alcoves and the oratory. Damaged surfaces impacted on effective cleaning.

Hand hygiene practice among staff was observed to be good and there were sufficient clinical hand-wash basins available to staff, however they did not meet national recommended standards. There was signage located throughout the designated centre which informed staff, residents and visitors of the protocols to follow to reduce the risk of infection, such as, the wearing of personal protective equipment (PPE), hand hygiene and respiratory etiquette.

The provider had installed closed cupboards in the clinical store area on the first floor. However, cleaning staff still had to access the cleaners room by walking through a clinical store room and there were equipment and items stored in open boxes on the floor of this room and could result in cross-contamination to these items.

The next two sections of the report will summarise the findings of the inspection and discuss levels of compliance under each regulation.

Capacity and capability

The registered provider demonstrated their efforts to provide a safe service for the residents in the centre although some further improvements were required. These improvements were required in relation to Governance and Management, Notification of incidents and Written policies and procedures.

The inspectors found that there was a clear governance and management structure in place. However, improvements were required in relation to ensuring the service provided was effectively monitored. The daily running of the centre was overseen by the person in charge with the support of a senior management team to include a Director of Clinical Operations. Signacare Killerig Limited is the registered provider for Signacare Killerig. The company is part of the Virtue Intergrated Care Group, which has a number of nursing homes nationally. The company has three directors, one of whom is the registered provider representative. The person in charge worked full-time and was supported by a clinical nurse manager, a team of nurses and health care assistants, activity co-ordinators, house keeping team, catering, administration and a full-time maintenance person.

The person in charge had notified the Chief Inspector of Social Services of all incidents which occurred in the centre within the required time-frame. However, not all restrictive measures in use such as sensor mats were reported. There were 13 sensor mats in use in the centre and these were recorded on the restraint register maintained in the centre.

The complaints procedure was not displayed in the centre. The registered provider representative assured the inspectors that this would be placed in a prominent place in the centre.

The registered provider had prepared in writing policies and procedures as required

for a designated centre. However, these policies required review as they had not all been reviewed to reflect changes in relation to the person in charge or the registered provider. The emergency policy had a contact number in place that no longer was in service. The person in charge informed inspectors that there was a new system under development and would be in place in the centre soon.

Prior to this inspection, the centre had experienced a COVID-19 outbreak. During this outbreak approximately a quarter of the residents and a small number of staff tested positive for COVID-19. At the time of this inspection residents and staff had completed their required period of isolation. The outbreak was seen to be managed well. For example: there was enhanced cleaning and dedicated staff were assigned to care for affected residents in efforts to prevent onward transmission of infection.

Overall accountability, responsibility and authority for infection prevention and control within the centre rested with the person in charge, who was also the designated COVID-19 lead. In their absence, the director of clinical operations nursing, became the lead for the recent outbreak, and had regular contact with the Public Health Department throughout the outbreak.

A review of documentation showed high levels of Legionella in water samples (Legionnaires' disease is a serious type of pneumonia (lung infection) caused by Legionella bacteria. People can get sick when they breathe in small droplets of water or accidentally swallow water containing Legionella into the lungs). The provider demonstrated that they took immediate and appropriate remedial action to address the identified risks.

Regulation 19: Directory of residents

The registered provider had established and maintained a Directory of Residents in the centre. This was made available to the inspectors.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had a contract of insurance against injury to residents in place.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place did not ensure the service was effectively monitored, for example;

- The nutritional audit had not picked up on the findings identified on this inspection.
- Minutes of management team meetings were not available in the centre.
- While residents meetings were taking place, the minutes of these meetings were not available on the day.
- Governance and management systems were not sufficiently robust to ensure effective oversight of service and infection prevention and control practices in the centre required action, as further detailed under Regulation 27: Infection control. While, infection control audits were carried out and recommended actions and responsible persons identified, the audit tools used did not identify findings on the inspection day. In addition, infection prevention and control training was undertaken via e-learning programmes. The findings of this inspection found that further training and supervision was required on standard infection control precautions, including safe sharps and appropriate clinical waste management and equipment hygiene practices and management of blood and body fluid spills.
- The annual review was not yet available for 2022.

Judgment: Not compliant

Regulation 31: Notification of incidents

The Chief Inspector of Social Services had been informed of all incidents which occurred in the centre within the required time-frame. However, not all restrictive measures in use such as sensor mats were reported.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations. However, these policies required review, for example;

- Responding to emergencies policy had the emergency contact number documented which was no longer in service.
- The complaints policy detailed the complaints officer as the previous person in charge.
- Fire safety management policy has the previous registered provider and

previous person in charge detailed as having responsibility for the centre.

Judgment: Substantially compliant

Quality and safety

Overall, residents received a good standard of care. Residents' health, social care and spiritual needs were catered for. However, further improvements were required in relation to residents' Individual assessment and care plan, Temporary absence or discharge of residents and Infection control. These will be discussed under there respective regulations.

The inspector saw evidence that the residents had access to their general practitioner (GP) including a medical review every four months. Although the residents' clinical care needs appeared to be met, the process for a pre-assessment prior to admission required review. Residents did not have a comprehensive assessment completed prior to admission.

Admission and transfer documentation reviewed did not include a comprehensive infection prevention and control history or risk assessment infections to support sharing of and access to information within and between services.

The centre had comprehensive care plans in place for residents receiving end of life care. Residents' wishes and preferences were clearly documented. However, care plans in other areas did not guide practice. Four out of six nutritional care plans reviewed did not reflect the current status of the residents, their requirements and any advice that had been provided in relation to monitoring the nutritional status of a resident.

Inspectors identified examples of good practice in the prevention and control of infection. Staff spoken with were knowledgeable of the early signs and symptoms of COVID-19 and influenza. The provider maintained records of influenza and COVID-19 vaccinations which were available for residents in the centre.

The centre was generally clean and well-maintained with a few exceptions. For example, there was damage to the edging of some residents' chest of drawers, commodes, flooring in the kitchen, physiotherapy area and a cleaners store room and a small number of cloth covered seating, which were unclean and not of a smooth surface to allow for effective cleaning.

The centre had a number of assurance processes in place in relation the standard of hygiene in the centre. These process included the use of colour coded cloths, mops and cleaning trollies to reduce the chance of cross infection. Household staff members who spoke with inspectors were knowledgeable with regard to cleaning processes. Clean and dirty laundry was seen to be managed safely in line with

national guidance.

Regulation 13: End of life

Where a resident is approaching end of life the person in charge had appropriate care and comfort measures in place which addresses the physical, emotional, social, psychological and spiritual needs of the residents concerned.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

Although records of resident's temporary transfers to hospital were maintained, the inspectors found that they were not appropriately completed in all cases, with gaps noted in some areas such as;

- The infection status for residents was not documented
- The health profile was not completed
- In one sample reviewed the information provided had the incorrect dates

Judgment: Substantially compliant

Regulation 27: Infection control

The registered provider had not ensured effective governance arrangements were in place to ensure the sustainable delivery of safe and effective infection prevention and control and antimicrobial stewardship. For example;

- the number of residents who had been prescribed antibiotics was monitored each month but the overall antimicrobial stewardship programme, to improve the quality of antibiotic use, needed to be further developed, strengthened and supported in order to progress. For example, audits of antibiotic use were not undertaken to ensure residents received the appropriate antibiotic
- there were gaps in information collected for surveillance of multi-drug resistant organisms (MDROs). This meant that the provider may not be able to monitor changes in infectious agents and trends in development of antimicrobial resistance. Additionally, there was some ambiguity among staff and management regarding which residents were colonised with MDROs and may result in inappropriate care been given
- a review of local infection prevention and control audits did not identify issues highlighted on this inspection and therefore failed to drive quality

improvement. For example it did not monitor all aspects of standard precautions.

The environment and equipment were not always managed in a way that minimised the risk of transmitting a healthcare-associated infection. For example;

- there was inappropriate storage on floors in clinical rooms and store rooms which impacted on effective cleaning. Dust and debris were observed under these boxes
- due to the location of the cleaners room and the clinical store room on the first floor, the layout may result in cross-contamination of items stored in open boxes on the floor and equipment stored in this area. This was a similar finding from the last inspection
- wear and tear was visible in some areas and the quality of surfaces and finishes on a small amount of bedroom furnishings, fittings and fixtures did not always support effective cleaning. Examples of this was seen in flooring in a store room, kitchen and physiotherapy area, stained cloth covered seating in the reception area and carpets in a store room and activity room, which did not allow for effective cleaning
- there was no hand wash sink in one of the cleaners' rooms. This did not support effective hand hygiene practice to minimise the risk of acquiring or transmitting infection
- two hoists and a small number of commodes inspected were seen to be unclean and/or had damaged surfaces. This meant that they had not been or could not be cleaned after each use.

The provider had not ensured that adequate precautions to ensure practices for effective infection control was part of routine delivery of care to protect people from preventable health care-associated infections. For example;

- the management of body fluid spillage procedures were not known fully by four staff members. This may result in ineffective cleaning and decontamination of surfaces
- Intravenous (I.V.) trays were unclean and all sharps bins inspected did not have the temporary closure mechanism engaged when they were not in use. One sharps bin was overfilled past the recommended fill line, had not been assembled correctly and staff did not have access to safety engineered needles. This was not in line with best practice and legislation. This meant that residents and staff could be inadvertently exposed to contaminated clinical waste
- open single use dressings were not used in line with their stated purpose. For example open dressings were stored with unopened dressings and may result in them being reused.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The person in charge did not ensure that each resident had an individual assessment and care plan in place to meet their identified clinical and care needs. This was evidenced by the following:

- The person in charge had not arranged a comprehensive assessment by appropriate health care professional prior to a resident's admission. Pre-admission assessments did not contain information with regard to MDROs, infections or vaccination status of residents being admitted to the centre. This may result in inappropriate measures being put in place to protect residents.
- Residents who had MDROs did not have care plans in place to guide care
- Care plans were not reviewed following a change in the resident's condition.
- One resident who had not been eating for more than seven days and had returned from the acute hospital had no nutritional care plan in place.

Judgment: Not compliant

Regulation 6: Health care

Residents were reviewed by their general practitioner (GP) within 48 hours of admission and had a medical review completed within a four month time period, or sooner if required.

There was evidence that residents had access to the required allied health professionals when required.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant

Compliance Plan for SignaCare Killerig OSV-0005454

Inspection ID: MON-0038491

Date of inspection: 03/04/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Director of Nursing has carried out a nutritional review on all residents and both the DON and Clinical nurse manager have received further training on auditing.

Completed

The Director of Nursing has the meeting minutes available in her office and the Director of operations will audit to ensure compliance with mandated meetings.
The residents were met and the Activities co-ordinater has all minutes and available to the Director of nursing in her absence.

Completed

A full review of the governance and management systems has been carried out by the RPR and Director of Clinical operations.
• Infection control link person identified, and IPC train the trainer being sourced.
• Training on the safe use of sharps bins completed.
• Management of blood and body fluids training completed.
• Annual review completed.
• IPC training will be given to all staff on-site.

There has been a robust comprehensive review of the governance and management in the centre. The Director of Clinical operations will be in the centre once a week to review the governance and management with the support of the registered provider representative.
The Director of nursing has a clinical governance meeting schedule to include Clinical and non-clinical review, IPC, Quality and Safety review .These meetings will be attended by Director of Clinical operations and/or Registered provider representative and will be

complemented by the weekly KPI reports and weekly staff meetings

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The center previously had not reported sensor mats as restrictive practice but as an enabler in the prevention of falls however going forward this will be included.

Completed

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The policies inspected by the inspector on the day of inspection were under review by the Director of nursing. The updated policies were on the computer system that all staff have access and had aknowledged. The Director of nursing has now printed the updated policies and they are available to staff on the computer and in hard copy at the nurses station to ensure clarity.

Completed

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
Temporary absence or discharge of residents: A full audit of all admission and transfer documentation has been carried out by the Director of nursing.
All resident health profiles have been reviewed to ensure they all contain accurate updated information.
All resident infection status has been audited to ensure documentation is current.

Completed

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

1. An Infection & MDRO tracker has been introduced within the center, this is completed by the nursing staff, as and when infections occur. Analysis of this is discussed at the weekly governance & monitoring meeting with the Director of Clinical Operations/Registered Provider Representative, with the GP during his clinic and then at the monthly governance team clinical meeting. This means that the provider will be able to monitor changes in infectious agents and trends in development of antimicrobial resistance.

Completed

2. A review of local infection prevention and control audit is underway by the QSR Officer – this will ensure that it covers antibiotic use and all aspects of standard infections.

3. A review of all the cleaning systems is underway by the General services manager, DON, CNM & newly appointed head of housekeeping. Specialist Equipment has been purchased to ensure compliance.

4. An overview of laundry facilities and action plan in place

Completed

5. All Storage areas cleared out - Floor & walls painted as necessary and new shelving put in.

Completed

6. The relocation of the cleaners room on the 1st Floor is under review by facilities to prevent any risk of cross contamination in the future.

7. All carpets to be removed and suitable flooring applied.

8. All soft furnishing in all areas of the centre will have a robust cleaning schedule going forward.

Completed

9. An environmental audit of the residents' bedrooms, equipment has been completed and an action plan compiled for maintenance to complete.

10. New commodes and shower chairs purchased; legs of Hoists sent for recoating. All on active cleaning schedule.

Completed

11. Flooring in Store painted.

Completed

12. Flooring in kitchen & Physio therapy room being addressed by facilities.

13. Clinical Room and equipment – daily cleaning schedule. Education given regarding sharp bin training, single use sign & dressings.

Completed

14. There are 2 Kits on each floor to facilitate compliance with the management of body fluid spillage procedures, staff have been educated in same, records maintained and this is included in induction process of all staff.

Completed

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
1. There is always a preassessment of all residents coming into the center, however the preassessment paperwork did not reflect the need for MDRO & Vaccination reporting. The preassessment form has been reviewed by the QSR Officer and this will now reflect all necessary information.

Completed

2. A new robust filing system is now in place to ensure immediate access to all residents' paperwork in their personal file. An audit into the Resident's MDRO history has been completed and the residents each have care plans to reflect this.

Completed

3. The Director of Nursing/CNM will ensure that all Residents on return from Hospital will have their medical history and care plans updated. This will be discussed, confirmed with records to reflect same.

Completed.

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 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	12/05/2023
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre,	Substantially Compliant	Yellow	12/05/2023

	hospital or place.			
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Not Compliant	Orange	01/10/2023
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2) (k) to (n) of Schedule 4.	Substantially Compliant	Yellow	12/05/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the Chief Inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	12/05/2023
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange	Not Compliant	Orange	01/10/2023

	to meet the needs of each resident when these have been assessed in accordance with paragraph (2).			
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	01/10/2023
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	01/10/2023