Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

# Report of an inspection of a Designated Centre for Disabilities (Mixed).

## Issued by the Chief Inspector

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| Name of designated centre: | Meath Westmeath Centre 1 |
| Name of provider: | Muiríosa Foundation |
| Address of centre: | Meath |
| Type of inspection: | Unannounced |
| Date of inspection: | 22 March 2022 |
| Centre ID: | OSV-0003957 |
| Fieldwork ID: | MON-0030399 |

## About the designated centre

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

The centre comprises two detached bungalows in close proximity to the nearest town. A full-time residential service is offered to six adults (male and female), each of whom has their own bedroom, and access to communal space and gardens in the houses. The provider describes the centre as offering support to individuals with medium support needs, including behaviours of concern and autism. The centre is staffed over 24 hours including sleepover staff at night. The staff team consists of social care workers and support workers. Residents are supported to access local amenities including GAA pitch, restaurants, leisure facilities and shops.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 5 |

## How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 |
|---|---|---|---|
| Tuesday 22 March 2022 | 09:20hrs to 17:30hrs | Karena Butler | Lead |

## What residents told us and what inspectors observed

Overall, the inspector found that residents in this centre were supported to enjoy a good quality of life which was respectful of their choices and wishes. However, there were improvements required in relation to individual assessment and personal plan, protection, training and staff development, premises, governance and management, protection against infection, fire precautions, and notification of incidents. These issues are discussed further in the next two sections of the report.

The inspector had the opportunity to meet and spend time with four of the five residents that lived in the centre. The centre was made up of two houses within close proximity of each other. The majority of residents in this centre attended an external day service. Most attended full-time and one attended on different days of the week. One resident availed of an in-house day service programme with dedicated day service staff to support them. One resident was attending day service on the day of inspection and the inspector did not get the opportunity to meet with them. The other resident from that house was observed to relax in their sitting room using an electronic tablet device. They later went out for a walk at a nearby lake and had a picnic. They chose not to spend much time with the inspector and their wishes were respected.

Residents in house two were not attending external day services the week of the inspection due to health reasons. They were being supported at home by the centre staff. They appeared content in each others company and were observed to move freely around their home. They were observed finishing their dinners, which they said they enjoyed. One resident communicated to the inspector that the staff member who cooked dinner was a good cook. Residents had gone for a walk around the local area earlier in the day and after dinner they all relaxed watching television and had plans to go for a drive that evening. They were observed to have friendly and relaxed interactions with staff. Residents communicated to the inspector that they liked their house. One resident recounted to the inspector about an interaction they had with one staff member earlier in the day, with both the resident and the staff then joking about what happened.

The inspector observed choice boards in the kitchen to facilitate residents to make choices about their day. Resident meetings took place weekly in the centre in order to keep residents informed and to offer choices around activities and meals.

There was one staff member on during the day in house one, with a small overlap of staffing to facilitate a drop off to day service, and two staff were on duty in the late afternoon. There were two staff on duty in house two on the day of inspection. Staff spoken with demonstrated that they were knowledgeable about the residents' care and support needs required. The inspector observed staff engagement with residents, which was found to be responsive and staff appeared familiar with residents' communication methods and were observed to communicate easily with

residents.

On entering both houses, the inspector saw that the physical environment of the houses was clean. However, both houses required some decorative and structural repair which will be discussed further in section two of this report.

There were many DVDs, art supplies, games and jigsaws, and house one had sensory objects avail for resident use. Each resident had their own bedroom that was individually decorated to their personal preferences. For example, one resident's bedroom was decorated with lots of sports memorabilia. There were adequate storage facilities for their personal belongings and there were personal items and pictures displayed in their bedrooms. One resident took pride in showing the inspector a framed picture of them with the horse riding ribbons they had won.

Each resident in house two gave the inspector a tour of their room and showed off items of personal interest to them. In particular they wanted to show the inspector the Mother's Day presents they had purchased for their mothers.

The properties had modest front gardens and both back gardens had seating areas for use in good weather. House one had a basketball hoop, footballs and a web swing for use. House two had a swing bench and potted flowers which a resident said they had planted.

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

## Capacity and capability

There were management systems in place to ensure good quality care was being delivered to the residents. However, the inspector found that these systems were not consistently implemented and improvements were required to governance and management, training and staff development, and notification of incidents.

The centre had a high turnover of management oversight across the previous year and the provider was recruiting for a permanent person in charge to take over the running of the centre. In the interim, a newly appointed area director was appointed as the person in charge. This person was employed in a full-time capacity and had the experience and qualifications to fulfil the role. The person in charge has a remit over a number of centres and in order to support them in their role there was also an newly appointed deputy. Staff spoken with were aware of who they reported to and there was a defined management structure in place.

Both the person in charge and the deputy were found to be responsive to the inspection process and aware of their legal remit with regard to the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres

for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). For example, they were aware that they had to notify the Chief Inspector of Social Services of any adverse incidents occurring in the centre, as required by the regulations. The were also aware that the statement of purpose had to be reviewed annually (or sooner), if required.

The provider had not carried out an annual review of the quality and safety of the centre and while there were arrangements for visits to the centre carried out on the provider's behalf on a six-monthly basis, only one of two required visits took place in 2021. The majority of actions that arose from the visit in December 2021 were still outstanding.

There were local audits and reviews conducted within the centre in areas such as medication, finance, first aid, and infection prevention and control. Actions identified from the previous Health Information and Quality Authority (HIQA) inspection had been addressed by the time of this inspection.

From a review of the rosters, the inspector saw that the roster in place accurately reflected the staffing arrangements in the centre.

Staff had access to the necessary training and development opportunities in order to carry out their roles effectively and to meet residents' assessed needs. For example, staff training included, safeguarding of vulnerable adults, medication management, and infection prevention and control trainings. However, it was difficult to ascertain if staff training was up to date from the training records. From documentation viewed staff required refresher training in a number of areas such as managing behaviour that is challenging, epilepsy and emergency medication, feeding eating drinking swallowing training, and fire safety training.

There were formalised supervision arrangements in place and staff spoken with said they felt supported in particular with the addition of the new deputy and would be comfortable bringing matters of concern to them if required. However, staff supervision was not always occurring in line with the organisational policy. There were monthly staff meetings occurring in the centre.

From a review of incidents that had occurred in the centre since the last inspection, the person in charge had not notified the Chief Inspector of Social Services (the Chief Inspector) in line with the regulations. The person in charge retrospectively submitted a notification with regard to an adverse incident that occurred in the centre at the end of 2021. While the Chief Inspector was notified regarding occasions in which a restrictive practice was used in the centre, the notification did not accurately notify the extent of a particular restrictive practice involved.

The inspector viewed the compliments and complaints folder for the centre and the centre had received one complaint in 2021 which was dealt with to the satisfaction of the complainant. The centre had also received two compliments from a family member in 2022 regarding staff, saying they went above and beyond for their family member.

## Regulation 14: Persons in charge

The person in charge had the necessary qualifications and experience to fulfil the role. They were employed in a full-time capacity.

Judgment: Compliant

## Regulation 15: Staffing

There were adequate staffing levels in the centre and staff spoken with appeared familiar with the residents care and support needs. The roster in place accurately reflected the staffing levels in place. Staff files were not reviewed as part of this inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

While staff had access to necessary training and development opportunities, a number of refresher trainings were overdue. It was difficult to ascertain if the training records were up to date in order to accurately reflect refresher training requirements. Staff supervision was not always occurring in line with the organisational policy.

Judgment: Substantially compliant

## Regulation 23: Governance and management

There had been a high turnover of management oversight within the centre over the previous year. Recruitment for a permanent person in charge was taking place at the time of inspection. One six-monthly visit as prescribed by the regulations had not occurred and the annual review for the centre for 2021 had not been completed. The majority of actions from the last six-monthly visit had not been completed by the time of the inspection.

Judgment: Not compliant

## Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre since the last inspection, the inspector found that the person in charge had not notified the Chief Inspector in line with the regulations. The person in charge retrospectively submitted the notification with regard to an adverse incident that occurred in the centre following this inspection.

While the Chief Inspector was notified regarding occasions in which a restrictive practice was used in the centre, the notification did not accurately notify the extent of a particular restrictive practice involved.

Judgment: Not compliant

## Regulation 34: Complaints procedure

From a review of the compliments and complaints, the centre had received one complaint in 2021 which was dealt with to the satisfaction level of the complainant. The centre had recently received two compliments from a family member in 2022 regarding the centre staff saying staff went above and beyond for their family member.

Judgment: Compliant

## Quality and safety

Overall, residents were receiving person-centred, quality care and supports that were focused on their needs. However, some improvements were required in relation to individualised assessment and personal plan, protection, premises, protection against infection and fire precautions.

There were arrangements in place to assess residents' needs and review the efficacy of the support plans in place with input from allied healthcare professionals as appropriate. However, some assessments of need and personal plans required review as it had been over a year since some had received a review.

Residents' healthcare needs were seen to be assessed and appropriate healthcare was made available to each resident. Residents had access to a range of allied health professionals which included a general practitioner (GP), massage therapy, physiotherapy, and speech and language therapy as required.

The inspector reviewed the arrangement in place to support residents' positive behaviour support needs. Where required, residents had access to members of a multidisciplinary team to support them to manage behaviour positively. These included a behavioural therapist and a senior clinical psychologist. There were positive behaviour support plans in place as required to guide staff as to how best to support the resident and staff spoken with were familiar with the strategies within the plans. Plans had been recently reviewed.

There were some restrictive practices in place, such as the press that contained chemicals was locked and external doors locked at night. Other restrictive practices were in place for specific residents to promote their mobility or support them with a specific diagnosis. Restrictive practices required for specific residents were assessed as clinically necessary for the resident's safety. Restrictive practices had recently been reviewed by the organisation's restrictive practice committee.

There were arrangements in place to protect residents from the risk of abuse. Staff were trained in adult safeguarding. Residents had intimate care plans to direct staff on their preferences and supports required. Residents' finances were checked and signed off by staff twice daily. There had been two incidents of peer-to-peer negative interactions in 2021 in one of the houses. While a formal safeguarding plan had been put in place after the first incident to safeguard the resident, it had not been reviewed in light of the second incident.

From a walkabout of the centre, the inspector found the houses were of an adequate size to meet the needs of the residents. Some areas required decorative or repair work such as repainting, removal of limescale build up, and some tiles required securing or the grouting replaced. Some improvement was required to ensure the houses looked homely. For example, the skirting board in one kitchen required upgrade to ensure it covered all the applicable area and repair was required to the top of the kitchen press. The deputy person in charge had completed an audit of the premises the day before the inspection and the majority of the issues identified by the inspector were identified on that audit and were reported to the maintenance department.

Risk management arrangements ensured that risks were identified, monitored and regularly reviewed. The inspector observed that the centre's vehicles were insured and had an up-to-date national car test (NCT) and one was in for service on the day of inspection. There was a policy on risk management available and a risk register in place which was under review at the time of inspection. Each resident had a number of individual risk assessments so as to support their overall safety and wellbeing.

The inspector reviewed arrangements in relation to infection prevention and control (IPC) management in the centre. There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19, with a contingency plan in place. Staff had been provided with relevant IPC training. Personal protective equipment (PPE) was available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff at all times due to social distancing not being possible to maintain in the centre. There were adequate hand-washing facilities and hand sanitising gels

available throughout the centre. However, there was some mildew observed in several areas and in particular on one resident's ceiling in several patches. Some documentation required review such as infection prevention and control folder to ensure all information contained is up to date and COVID-19 risk assessments all required review to ensure they were still accurate and control measures appropriate. Mops and buckets in house two were stored inappropriately outside.

There were fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which were regularly serviced. Staff had received training in fire safety and there were fire evacuation plans in place for residents. Monthly fire evacuation drills had been conducted using minimum staffing levels to ensure all residents could be evacuated. However, two fire containment doors in house one were wedged open to allow easier access for residents. This required improvement to ensure the residents could evacuate safely and were protected from the spread of fire and smoke in the event of a fire. In house two one self-closure device was broken. The broken self-closure had also been identified on a recent audit completed and a maintenance request was submitted.

## Regulation 17: Premises

The inspector found the houses were of an adequate size to meet the needs of the residents. However, some improvement was required to ensure the houses looked homely. For example, the skirting board in kitchen one required upgrade to ensure it covered all the applicable area and repair was required to the top of one area of the kitchen presses. Some areas required decorative or repair work such as repainting, removal of limescale build up, some tiles required securing or the grouting replaced.

A premises audit had been completed the day before the inspection and the majority of the issues identified by the inspector were identified on that audit and were reported to the maintenance department.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

Risk management arrangements ensured that risks were identified, monitored and regularly reviewed. The centre's vehicles were insured and had an up to date national car test (NCT) and one was in for service on the day of inspection. There was a risk management policy available and the centre had risk register in place which was under review at the time of inspection. Each resident had a number of individual risk assessments so as to support their overall safety and wellbeing.

Judgment: Compliant

## Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19, with a contingency plan in place. However, mildew was observed in several areas and in particular on one resident's ceiling in several patches. Some of the identified mildew had been self identified by the deputy person in charge and reported to maintenance.

Some documentation required review such as infection prevention and control folder to ensure all information contained is up to date and COVID-19 risk assessments all required review to ensure they were still accurate and control measures appropriate.

Mops and buckets in house two were stored inappropriately outside.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

While the provider had fire safety arrangements in place two fire containment doors in house one were wedged open to allow easier access for residents. This could allow for the spread of fire and smoke in the event of a fire. In house two, one self-closure device was broken. The broken self-closure had been identified on a recent audit completed by the deputy person in charge and a maintenance request was sent.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

There were arrangements in place to assess residents' needs and review the efficacy of the support plans in place with input from allied healthcare professionals as appropriate. However, some assessments of need and personal plans required review as it had been over a year since some had received a review. This is to ensure that all supports are appropriately identified and all identified needs have accurate plans.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents' healthcare needs were seen to be assessed and appropriate healthcare was made available to each resident. Residents had access to a range of allied health professionals which included a general practitioner (GP), massage therapy, physiotherapy, and speech and language therapy as required.

Judgment: Compliant

## Regulation 7: Positive behavioural support

There were arrangements in place to support residents' positive behaviour support needs. Where required, residents had access to members of a multidisciplinary team to support them to manage behaviour positively such as a behavioural therapist and a senior clinical psychologist. Positive behaviour support plans were in place as required to guide staff as to how best to support the resident and staff spoken with were familiar with the strategies within the plans. Plans had been recently reviewed.

While there were some restrictive practices in place, they were assessed as clinically necessary for the resident's safety. For example, there were restrictive practices in place for specific residents to promote their mobility or support them with a specific diagnosis. Restrictive practices had recently been reviewed by the organisation's restrictive practice committee.

Judgment: Compliant

## Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. Staff were trained in adult safeguarding. Residents had intimate care plans that directed staff on their supports and preferences required. Residents' finances were reviewed and signed off by staff twice daily. There were two incidents of peer-to-peer negative interactions in 2021 in one of the houses. While a formal safeguarding plan had been implemented as a result of the first incident, it had not been reviewed in light of the second incident to ensure measures were appropriate.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

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| The inspector observed choice boards in the kitchen to facilitate residents to make choices about their day. Resident meetings occurred weekly in the centre were staff kept residents of necessary information and to offer choices around activities and meals. |
| 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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 27: Protection against infection | Substantially compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Substantially compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Meath Westmeath Centre 1 OSV-0003957

## Inspection ID: MON-0030399

## Date of inspection: 22/03/2022

**Introduction and instruction**
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>An overview of staff training has taken place. All staff identified as needing training have been referred on to the training department. Dates have been issued for online training, links have been sent out. Staff have completed a number of training modules. One staff member is still awaiting training and has been put forward for training. Supervision will be scheduled and facilitated over the coming weeks.<br><br>Date to be completed: 30th June 2022 | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>A recruitment campaign has been successful and PIC has been progressed. The Centre has received its 1st six monthly audit for 2022 and the 2nd will take place later in the year. The annual report for 2021 is under completion and will be finalised by 11th May 2022. A review of the actions from the last 6 monthly audit will take place and all actions will be closed off in a timely manner.<br><br>Date to be completed: 11th May 2022 | |

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The restrictive practice in place has been clarified by the PPIM. Any high risk food is stored in the fridge in the office; this is due to the risk of dysphagia. The high risk food is listed and going forward will be reported fully on the quarterly notifications and reviewed accordingly.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
To ensure a good state of repair is achieved the Person in Charge has submitted through the monthly maintenances request system.

Date to be completed: 31st May 2022

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| Regulation 27: Protection against infection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All documentation has been reviewed and updated. Mops and buckets are now stored appropriately in the shed.
Additionally, we have recently introduced a new mop/bucket storage system, which will be housed externally. Two of these storage units have been ordered for the centers, which will house all the mops and buckets. There are special hooks to hang the mops, reducing the likelihood of mops being left in the buckets.
Maintenance team have been in and have cleared the mould/mildew from the bedrooms and other areas. As part of our continuing efforts to be proactive in IPC, cleaning schedules have been amended to report any issue of mould.

Completed - Mop/bucket storage unit 5 week lead time 03.06.22

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| Regulation 28: Fire precautions | Not Compliant |
| Outline how you are going to come into compliance with Regulation 28: Fire precautions: All staff have been informed not to wedge fire doors open. All door wedges have been removed. A request has been submitted for magnetic self-closing door. The broken self - closure has been rectified and is operational. Staff have been sent links to update Fire safety training.<br><br>Completed | |
| Regulation 5: Individual assessment and personal plan | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>In order to comply with Regulation 5 the Person in Charge will arrange for :<br><br>1) A review of all Personal Plans to ensure appropriate healthcare needs are detailed.<br>2) Review of all Service Users Assessment of Needs<br><br>Date to be completed: 31st May 2022 | |
| Regulation 8: Protection | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 8: Protection: Safeguarding plan has been reviewed and will be reviewed again in 6 months or earlier if required.<br><br>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 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 06/05/2022 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 30/06/2022 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 31/05/2022 |
| Regulation 17(1)(c) | The registered provider shall ensure the premises of the | Substantially Compliant | Yellow | 31/05/2022 |

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| | designated centre are clean and suitably decorated. | | | |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange | 06/05/2022 |
| Regulation 27 | The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. | Substantially Compliant | Yellow | 06/04/2022 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/03/2022 |
| Regulation 31(1)(f) | The person in charge shall give the chief inspector notice in writing within 3 working | Not Compliant | Orange | 30/03/2022 |

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| | days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident. | | | |
| Regulation 31(3)(a) | The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used. | Substantially Compliant | Yellow | 11/05/2022 |
| Regulation 05(1)(b) | The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual | Substantially Compliant | Yellow | 31/05/2022 |

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| | basis. | | | |
| Regulation 05(6)(c) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan. | Substantially Compliant | Yellow | 31/05/2022 |
| Regulation 08(3) | The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse. | Substantially Compliant | Yellow | 30/03/2022 |