Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Alpine Services
Name of provider:	Ability West
Address of centre:	Galway
Type of inspection:	Unannounced
Date of inspection:	27 November 2023
Centre ID:	OSV-0004069
Fieldwork ID:	MON-0041324

About the designated centre

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

Alpine Service provides respite care to 5 male and female people with an intellectual disability who require a support level ranging from minimum to high, and who are over 18 years of age. The service provides planned, short-term, recurrent respite breaks of varying durations. The centre is a large, well-equipped building linked to a day service in a rural town. All residential accommodation is on the ground floor of the building, and residents have their own bedrooms during respite breaks. The centre is centrally located and is close to amenities such as shops, restaurants, a church, and pharmacy service. Residents are supported by a staff team which includes the person in charge, social care workers and care assistants. Staff are based in the centre when residents are present and a staff member remains on duty at night to support residents. The person on charge is based in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	1

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
Monday 27 November 2023	09:30hrs to 15:00hrs	Mary Costelloe	Lead

What residents told us and what inspectors observed

This was an unannounced inspection to assess the provider's overall compliance with the regulations, to follow-up on the findings of the previous inspection carried out in May 2022, and to also assess the progress made by the provider in implementing their own quality improvement plan for the organisation, which they submitted to the Chief Inspector of Social Services in April 2023. The inspection was facilitated by the person in charge. The inspector also met with two staff members and briefly met with one service user who avails of respite.

Alpine services provides a respite service for 20 service users, however, a maximum of five service users can be accommodated on any one night. The person in charge advised that currently a maximum of four service users were being accommodated per night with only one service user being accommodated on some nights. Length of stays varied from one to two nights during the weekdays and three nights at weekends. Service users attended their respective day services during the weekdays. They usually arrived in the centre in the late afternoon and left again in the morning to attend their day services.

On the morning of inspection, there had been four service users availing of respite service the previous night. All had already left the centre to attend their respective day services. There was one service user due to arrive in the centre during the late afternoon to avail of the service. While the inspector did not meet with any of the service users who were staying on the day of inspection, they did meet briefly with another service user who avails of the respite service. Staff introduced the inspector to this service user and explained why the inspector was visiting the centre. The service user appeared to be very happy and relaxed in the company of staff and stated that they liked availing of and staying overnight in the respite service.

The centre was single storey but part of and connected to a two storey building which was used by day services. All residents were accommodated in single bedrooms which were spacious and bright. There was adequate personal storage space provided in each room and there were lockable storage facilities available for residents to store personal items between stays. Residents had chosen their own bed linen which was laundered and appropriately stored between stays. Residents shared a large well-equipped shower room and two toilets. Residents had access to a large kitchen, dining room and day room. There was also a utility room used for laundry and storage of cleaning equipment. Residents had access to a secure outdoor paved garden area which contained a variety of colourful pots and plants and a range of outdoor furniture. The building was found to be well maintained and visibly clean throughout. Improvements including a new fitted kitchen and new sofas had been provided since the previous inspection. The centre was located in a rural town and close to a number of larger towns with good access to a range of facilities and amenities. The centre had its own minibus which residents used to go on outings, day trips and attend activities.

From a review of documentation, minutes of house meetings and photographs as well as speaking with staff, it was clear that service users continued to enjoy a range of activities while availing of the respite service. Staff reported that service users were consulted with as to their individual preferred choice of outings and activities. They reported that some liked to go for walks or drives in the bus, some liked to go shopping or eat out, others liked to visit religious sites or visit the local church, some enjoyed attending the cinema or going on day trips to places of specific interest. Staff reported that some service users had enjoyed attending the switching on of the Christmas lights in a nearby large urban town over the weekend while others had recently enjoyed attending a musical in the local school. Some service users liked to relax and remain in the centre, watching television, listening to music, playing with puzzles, participating in baking, interacting with staff or having a massage. Service users and their families had recently completed feedback questionnaires, the results of which had indicated overall satisfaction with the quality of the service.

Overall, the inspector found that the specific areas requiring improvement from the last inspection had been addressed. The local management were striving towards further improvements in order to address findings from a recent provider led audit. However, further improvements were required particularly in relation to the oversight of fire safety management. Further clarity was required in relation to procedures in place in the event of fire at night time in the building and assurances were required around the ability of staff to support the safe and timely evacuation of residents in the event of fire at night time.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents lives.

Capacity and capability

This designated centre is run by Ability West. Due to concerns in relation to Regulation 23: Governance and management, Regulation 15: Staffing, Regulation 14: Person in Charge, Regulation 5: Individualised assessment and personal plan, and Regulation 26: Risk management procedures, the Chief Inspector of Social Services is undertaking a targeted inspection programme in the provider's registered centres with a focus on these regulations. The provider submitted a service improvement plan to the Chief Inspector in April 2023 highlighting how they will come into compliance with the regulations as cited in the Health Act 2007 (as amended). As part of this service improvement plan the provider has outlined an action plan to the Chief Inspector highlighting the steps they will take to improve compliance in the registered centres. These regulations were reviewed on this inspection and this report will outline the findings found on inspection.

The findings from this inspection showed that the provider had implemented the

specific areas requiring improvement as outlined in the compliance plan from the last inspection. Improvements were noted to on-call management arrangements, infection, prevention and control, and the premises. The local management team had brought about improvements to some medication management practices and further in-house training had been scheduled on fire safety in response to findings from a recent provider led audit. However, further improvements were required to the oversight and management of fire safety and risk management. The storage of some unused equipment also required review.

The person in charge worked full-time in the centre. They had been allocated 24 hours a week to their operational management role and also worked as a social care worker on the floor. The person in charge was supported in their role by a senior manager. There were now formal on-call management arrangements in place for out-of-hours seven days a week. The details of the on-call arrangements were notified to staff on a weekly basis and clearly displayed in the centre. Staff spoken with were familiar with the arrangements in place.

At the time of inspection there were stable staffing arrangements in place. The person in charge advised that there were no staff vacancies with a full compliment of staff available. Most staff members had worked in the centre over a sustained time period and knew the service users well and had developed good relationships with them and their families. Staff spoken with were knowledgeable regarding service users up-to-date support needs, they advised that staffing levels in the centre were flexible in order to meet the assessed support needs and number of respite residents availing of the service at any given time.

Staff training records reviewed indicated that that all staff including relief staff had completed mandatory training. Additional training in various aspects of infection prevention and control, medication and epilepsy management, open disclosure, feeding, eating, drinking and swallowing guidelines had been completed by staff. Further training was scheduled in relation to fire safety and operation of the fire alarm system as well as epilepsy training for a recently recruited staff member. The person in charge continued to review and maintain oversight of staff training needs.

The person in charge had systems in place to regularly monitor and review areas such as accidents and incidents, restrictive practices, medicines management, infection, prevention and control, fire safety and residents finances. Monthly team meetings were taking place at which identified areas for improvement were discussed and learning shared. Minutes of a recent meeting reviewed indicated that discussions with the designated officer following a peer to peer incident had been shared with staff. There was also evidence of consultation with residents with weekly house meetings where the views of residents were sought and information shared. The minutes of a recent meeting reviewed showed that residents had been consulted with regard to their preferred activities and choice of menu, the 'right to feel safe' policy had also been discussed.

The provider had systems in place to monitor and review the quality of the service, including an annual review of the service and six-monthly provider led audits. The annual review dated January 2023 had been completed and included evidence of

consultation with residents and their families. The overall feedback was complimentary of the service provided. The inspector noted that a recently completed provider led audit was more comprehensive and had also reflected on areas for improvement that had been identified across other centres in the organisation. Non compliance's and improvements identified were included in an action plan. The local management team had brought about improvements in response to the findings and further training was scheduled to take place in relation to some aspects of fire safety. However, the inspector noted further improvements and clarity were required to fire safety management which are discussed further under the quality and safety section of this report and under regulation 28:Fire safety.

Regulation 14: Persons in charge

There was a person in charge who had responsibility for the day-to-day management of the centre. The person in charge worked full-time in the centre and had the required qualifications and experience to manage the centre as required by the regulations. They were knowledgeable regarding the regulations and their statutory responsibilities. They had worked in the role since 2016 and were well known to staff, service users and their families.

Judgment: Compliant

Regulation 15: Staffing

There were adequate staff on duty to meet the assessed needs of service users. The staffing roster reviewed indicated that there was a regular staff pattern. These staff were employed on a regular basis by the provider and had developed good relationships with the residents. The staff roster had been completed to the end of January 2024. The staff member in charge of each shift was clearly identified.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that all staff had access to appropriate training including refresher training. Training records reviewed and staff spoken with indicated that all staff had completed mandatory training in areas such as manual handling, managing challenging behaviour, safeguarding, fire safety and infection,

prevention and control.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were required to management systems to ensure that the service provided was safe and effectively monitored. Further oversight, clarity and improvements were required to ensure effective fire safety management and to the identification and assessment of risk in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector reviewed the statement of purpose recently submitted with the application to renew registration of this centre. It requires some updating in order to fully comply with the regulations. The registered provider representative (RPR) named in the document was found to be incorrect as the person identified was not a board member.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The inspector was satisfied that complaints received to date during 2023 had been managed in line with the complaints policy. The complaints procedure was clearly displayed and also available in an easy read format. The details of two verbal complaints received during 2023 had been logged on the computerised information management system. These complaints had been managed locally by the person in charge. Records reviewed indicated that both complainants were satisfied with the response and outcome.

Judgment: Compliant

Quality and safety

Overall, there was evidence that a good quality service was being provided to respite users, there were adequate staff resources in place to ensure that respite users got out and engaged in their desired activities, however, improvements were required to fire safety management to ensure that they were safe while availing of respite in the centre.

Staff spoken with were familiar with, and knowledgeable regarding service users' up to date health-care needs. They advised that residents were generally in good health and there were no service users currently with mobility issues. Staff reported that some residents had specific health-care needs, and some required supports with feeding, eating and drinking guidelines as recommended by the speech and language therapist (SALT), while others needed support with managing behaviour that challenged. Staff advised that due to the respite nature of the service that the families arranged and supported service users' attend all medical and health care appointments. The inspector reviewed a sample of service users' files. There were up-to-date assessments of need completed, care and support plans were in place for all identified issues including specific medical conditions, and there was evidence that they were reviewed regularly.

Service users' had access to a general practitioner(GP) and out of hours GP service while availing of respite service in the centre. They had an up-to-date hospital passport which included important and information specific to each service user in the event of they requiring hospital admission in an emergency.

Personal plans had been developed in consultation with service users, their family members and staff. The plans set out the services and supports provided for residents to achieve a good quality of life and realise their goals while availing of the respite service. Review meetings took place annually, at which, residents' personal goals and support needs for the coming year were discussed and progress reviewed. Each resident's personal outcomes for the year were documented in an easy-to-read picture format. It was clear that all residents were supported to progress and achieve their chosen goals. There were regular progress notes recorded and photographs demonstrating achievement of goals.

All staff had received training in supporting residents manage their behaviour. Residents who required support had access to psychology services and had positive behaviour support plans in place. Staff continued to promote a restraint free environment. While there were some restrictions in use, there was a clear rationale outlined for their use as well as evidence of consultation and consent recorded. There were risk assessments completed, and multidisciplinary input into the decisions taken for restrictions in use. The restrictions in use had been referred to the restrictive practice committee and had been recently reviewed and approved.

The person in charge had systems in place for ensuring oversight of medication management practices. All staff had received training in medicines management. There were no controlled medicines prescribed for service users at the time of inspection. While there were no medicines in the centre at the time of inspection, there was secure storage facilities available for the storage of same. Respite users brought their medicines to the centre when staying for respite. There were systems

in place for logging all medicines on the arrival of service users to the centre and again when they were leaving. All service users continued to have a choice of pharmacist. A review of a sample of medicine prescribing and administration charts showed that all medicines were prescribed, regularly reviewed and signed by the GP. Medicines were being administered as prescribed. The person in charge advised that there were no recent medicines errors and regular reviews of medicines management practices continued to take place.

While there were systems in place for the management and on-going review of risks in the centre, further improvements were required. The person in charge had systems in place to regularly review and update the risk register. The provider had an escalation pathway available to the person in charge, to raise these risks with senior management. The top five risks in the centre were submitted on a monthly basis to the senior management team for review. However, it was noted that some risk ratings and control measures in place required review to accurately reflect risk in the centre. For example, fire safety was risk rated as low, however, given the recent findings of a provider led audit which identified fire safety as non-compliant and given the findings on this inspection, this risk rating was not reflective of risk in the centre.

Further oversight, clarity and improvements were required to fire safety management in the centre. There was a regularly serviced fully addressable fire alarm system and suitable fire fighting equipment in place. Daily, weekly and monthly fire safety checks were recorded. Regular fire drills had taken place involving staff and service users, while a fire drill had been completed simulating a night time time scenario, it had been completed when only one resident was availing of the service. There had been no fire drill carried out to provide assurances that up to five residents could be evacuated safety in a timely manner at night time when there was only one staff member on duty. The door between the kitchen and main communal areas of the centre was not closing properly which could result in the spread of smoke in the event of fire. The fire alarm panel was situated in the shared entrance lobby area located between the day centre and the respite centre. The fire alarm panel served both centres. The layout floor plan of the day services centre was displayed adjacent to the panel, however, the plan did not include the respite centre which posed a risk and could cause confusion or delay in locating a fire. Further clarity was required in relation to procedures in place in the event of fire, particularly, should this occur in the day services section of the building, given that this section of the building is not occupied at night time, is a large two storey building, there is only one staff member on duty at night time in the respite centre and according to information provided by the person in charge, the building had not been constructed to provide separate fire compartments.

Regulation 26: Risk management procedures

Improvements were required to the identification and assessment of risk in the centre. Some risk ratings and control measures in place in relation to identified risks

required review to reflect risk in the centre. For example, fire safety was risk rated as low, however, given the recent findings of a provider led audit which identified fire safety as non-compliant and given the findings on this inspection, this risk rating was not reflective of risk in the centre. Control measures such as fire safety training for all staff had not been identified a control measure on the register. Additional risks in relation to fire safety management as noted on the day of inspection had not been identified.

Judgment: Not compliant

Regulation 28: Fire precautions

Further oversight, clarity and improvements were required to fire safety management in the centre to ensure that all service users and staff were safe. There had been no fire drill carried out to provide assurances that up to five residents could be evacuated safety in a timely manner at night time when there was only one staff member on duty. The door between the kitchen and main communal areas of the centre was not properly closing which could result in the spread of smoke in the event of fire. The fire alarm panel was situated in the shared entrance lobby area located between the day centre and the respite centre, the alarm served both centres. The layout plan of the day services centre was displayed adjacent to the panel, however, the plan did not include all areas of the respite centre which posed a risk and could result in a delay in locating a fire. Further clarity was required in relation to procedures in place in the event of fire, particularly, should this occur in the day services section of the building, given that this section of the building is not occupied at night time, is a large two storey building, there is only one staff member on duty at night time in the adjoining respite centre and according to information provided by the person in charge, the building had not been constructed to provide separate fire compartments.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The provider had systems in place for the safe prescribing, administration and storage of medicines in this centre. Clear prescription records were maintained. Records reviewed showed that medications were administered as prescribed. Medication audits were frequently carried out to identify any improvements that may be required and to ensure a high standard of compliance was maintained. All staff had completed training in medicines management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Service users' health, personal and social care needs were assessed and care plans were developed, where required. The inspector reviewed a sample of respite users files and noted that support plans were in place for all identified issues. Support plans were found to be individualised, person centered and provided clear guidance for staff. Residents were supported to identify and achieve personal goals. Annual meetings were held with residents and their family representatives where appropriate and regular reviews took place to track progress of identified goals. Files and photographs reviewed showed that residents had been supported to achieve their chosen goals to date during 2023.

Judgment: Compliant

Regulation 6: Health care

Due to the nature of this respite service, families generally arranged and supported service users' attend all medical and health care appointments. However, respite service users continued to have access to general practitioners (GPs) and health and some social care professionals while availing of respite. A review of a sample of service users' files indicated that some had been regularly reviewed by the psychologist and speech and language therapist.

Judgment: Compliant

Regulation 7: Positive behavioural support

All staff had received training in supporting service users manage their behaviour. Those who required support had access to psychology services and had positive behaviour support plans in place. Staff continued to promote a restraint free environment. Restrictions in place were regularly reviewed. There was multidisciplinary input into the decisions taken, a risk assessment and clear rationale outlined for restrictions in use.

Judgment: Compliant

Regulation 9: Residents' rights

Service users Service users were supported to live person-centred lives where their rights and choices were respected and promoted. Staff continued to ensure that respite service users' preferences were met through daily consultation, weekly house meetings, the personal planning process and ongoing communication with them and their representatives. Information was available to service users in a suitable accessible format. Service users were supported to communicate in accordance with their needs. Service users were supported to attend religious services of their choice. Some liked to visit religious shrines and cathedrals while others preferred to visit local churches and light candles.
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	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Alpine Services OSV-0004069

Inspection ID: MON-0041324

Date of inspection: 27/11/2023

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 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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge has requested from the Manager of Ancillary services, that all fire doors are thoroughly inspected and repaired to Fire safety standard by fire safety specialist. 22/12/2023 Fire panel training completed by all staff 5/12/2023. Simulated fire drills completed by all staff at team meeting 5/12/2023. Envisaged what order service users should be evacuated, especially the more challenging service users. Questions and answers discussed thoroughly and examples of different scenarios discussed. All service users PEEPs reviewed. There is a schedule of night fire drills in place for the first quarter of 2024, to include all staff team and service users attending respite.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Registered Provider Representatives name has been removed and an up to date version is now on file.	

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Risk Register has been reviewed and updated to reflect the current rating of the specific risk on Fire Safety. Control measures have been added to reflect what is required to meet the standards of Risk management. The Risk Register will be reviewed and updated accordingly as these control measures are in place.
There is a schedule of fire drills in place for the first quarter of 2024, to include all staff team and service users attending respite.
Fire panel training completed by all staff 5/12/2023.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Night drills were completed 8/12/2023, 10/12/2023 and 12/12/2023 by one staff and the current maximum of four service users and observed by another staff member. There is a planned night drill scheduled for 21/12/2023 also. Following this, twelve out of twenty residents will have been included in a night drill. The Person in Charge has a schedule in place to ensure all service users are included in a night drill by 31/3/2024. A night fire drill will be completed to include five service users when a maximum of five residents are in attendance.
The fire door in the kitchen and all other fire doors are due for inspection and correction by the fire safety specialist 22/12/2023.
The layout plan (floor plan) for the respite centre is now fully displayed next to the fire panel. Alpine respite has an addressable fire system which informs staff of the exact location of the fire.
The CEEP has been reviewed to clearly outline to night staff on duty, procedures in relation to evacuation should a fire occur in the Day service section of the building.

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(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.	Substantially Compliant	Yellow	31/12/2023
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	31/12/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	31/03/2024

	evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	22/12/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	06/12/2023