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:	No.5 Fuchsia Drive
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	24 August 2021
Centre ID:	OSV-0004577
Fieldwork ID:	MON-0034059

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of four residents; however, a shared care arrangement with home is also facilitated. All of the residents in the context of their disability require support from staff but the level of support provided is individualised and advised by an assessment of each resident's needs and preferences. For example some residents may require minimal staff support for some daily routines such as personal care but would have a requirement for more staff support in other areas such as monitoring of health and well-being. The provider aims to support residents to live ordinary lives as valued citizens in their community while remaining connected to family and friends. The provider strives to provide each resident with a safe home and quality support that meets their assessed needs and personal choices.

The centre is located in a mature residential setting on the outskirts of the busy local town; transport to the amenities offered by the town and the services utilised by the residents is available. The premises itself is a dormer type property with a garden to the rear.

The model of care is social and given the level of support needed from staff there are ordinarily two staff on duty when residents are present in the house with the exception of the night-time arrangement which is one staff on sleepover duty. The staff team is comprised of care assistants and social care workers; supervision and day-to-day general oversight is provided by the unit leader under the direction and supervision of the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 - 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
Tuesday 24 August 2021	9:00 am to 5:15 pm	Lisa Redmond	Lead

What residents told us and what inspectors observed

From what the inspector observed, information reviewed and what was communicated to them during the inspection, it was evident that there were significant risk issues in the centre that impacted on the safety of residents living in the centre. As a result of the evidence in this report, and given the number of not compliant findings identified during this inspection, it was not evident that the registered provider could ensure the effective governance, operational management and administration of the designated centre.

On the day of the inspection, the inspector met with the four residents who lived in the designated centre. On arrival, residents were getting up and getting ready for the day ahead. The inspector chatted to residents about their life in the centre, and the supports they received there.

One resident was observed having a drink and their breakfast on the morning of the inspection. The inspector sat at the kitchen table with them, and chatted to them and the staff working with them. The resident used sounds, gestures, manual signing and prompting to communicate their needs to staff members. As the resident ate their breakfast, staff members told the inspector that the resident had their food at a specific consistency, following review from a speech and language therapist. The inspector observed staff members checking the consistency of the resident's breakfast, to ensure it was in line with the speech and language therapist's recommendations. One staff member stayed in the kitchen and observed the resident as they ate their breakfast. It was evident that the resident enjoyed their breakfast, and they were observed smiling and gesturing that they wanted to make sure they ate all of it.

The inspector met another resident who was relaxing on the couch in their kitchen and living area. The resident said they liked having their own self-contained living area, and that they had a cosy bed in their bedroom. The resident showed the inspector photographs that were displayed in their home, and it was evident that they were meaningful to the resident. The inspector met the resident later in the day, after they had been for a drive with staff members. The resident told the inspector that they were tired after their busy day, so the inspector said goodbye and left them to relax and rest.

One resident chatted with the inspector as they headed out for a coffee with staff members. On their return, the inspector met them as they were relaxing in the kitchen of their self-contained living area. The resident laughed and smiled as they showed the inspector a photograph of them wearing a Garda hat, with a member of an Garda Síochána (Irish police).

The premises of the designated centre contained a main house where three residents lived. There was one self-contained apartment where one resident was supported individually. An extension had been added to the premises in 2020. It was

identified during the inspection that the footprint of the centre did not match the floor plans that were located throughout the designated centre, or those submitted to the Health information and Quality Authority (HIQA), following their most recent application to renew the registration of the designated centre. It was identified that an application to register the designated centre to include the extension and layout of the centre had not been completed. This was a breach of the designated centre's registration conditions.

The residents' home appeared to be homely in nature. There was evidence of a number of private and communal areas where residents could relax. There was a garden area to the back of the centre. There was also a small covered over area where one resident enjoyed to sit outside. It was evident that there was a lack of storage space for residents' personal belongings. It was also noted that some areas required repair including a bathroom light fixture.

It was noted that there was an odour from a nearby bathroom evident in the kitchen areas that supported 3 residents. At the time the inspector and staff members noted the odour, one resident was having their breakfast. Staff members told the inspector that two of the residents' bathrooms had recently been renovated, in line with their assessed needs. One of these bathrooms was the one where the odour appeared to be coming from. The person in charge told the inspector that there were plans to replace the flooring in one resident's bedroom which should rectify the issue.

When the inspector entered the designated centre on the morning of the inspection, they noticed that the fire-resistant door between the utility room and one kitchen was wedged open. The door wedge was immediately removed, and this was highlighted to staff members on duty. The inspector checked the fire-resistant doors in the centre and noticed that three of these doors had partial intumescent stripping missing. Intumescent stripping is designed to expand when a fire breaks out, sealing the gap around the door frame and therefore containing smoke and fire.

When the person in charge arrived to the centre, an introductory meeting was held with them and the inspector. The purpose of this meeting is to discuss the plan for the inspection, and seek information about the services provided to residents living in the centre. The issues with the fire doors were highlighted to the person in charge at the introductory meeting, and it was agreed that a walk around of the designated centre would then be completed.

The person in charge showed the inspector around the designated centre. It was identified that two fire exits were blocked by residents' personal belongings. The first exit was located in a resident's bedroom. The layout of the resident's bedroom meant that it exited into a kitchen, and also into a corridor. The exit into the corridor was blocked by the resident's personal belongings, which meant that it could not be accessed in the event of a fire. It was noted that if a fire were to break out in the kitchen area, the resident's belongings would impact on their ability to safely evacuate the designated centre, from their bedroom.

The second exit that was blocked was located in another resident's bedroom. The layout of the resident's bedroom meant that it exited directly outside through a patio

door, or into a small kitchen and dining area. The patio door was blocked by a number of large storage boxes, which were filled with the resident's belongings. This exit could not be accessed in the event of a fire. It was noted that if a fire were to break out in the kitchen and dining area, the resident's belongings would impact on their ability to safely evacuate the designated centre, from their bedroom.

Due to the serious nature of these findings, two immediate actions were issued to the registered provider. The immediate actions were issued for the two fire exits that were blocked in the residents' bedrooms. An immediate action is used by the HIQA when a risk that needs to be addressed without delay is identified. The risk must be mitigated before the end of the inspection. The registered provider removed the items that were blocking these exits, before the end of the inspection.

It was decided that as a result of the serious findings under regulation 28 fire precautions, that the planned unannounced inspection would be changed to a risk based inspection. Risk based inspections are completed when there is evidence or information that indicates a potential risk to residents. Risk based inspections are focused inspections, focused on providing assurances about the safety of the service provided to residents under a number of key regulations. The regulations outlined in this report are those that required review to ensure the safety of residents living in this centre.

The next two sections of this report will present 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 service being provided.

Capacity and capability

It was evident that significant improvements were required to ensure that there was effective oversight of the designated centre, and that it provided a safe service to residents in line with their assessed needs.

The skill-mix of staff members working in the centre were care assistants and social care workers. There was one social care leader also assigned to the centre. These staff all reported to the person in charge who fulfilled the role for a total of four designated centres. It was noted in the designated centre's statement of purpose that the person in charge was assigned to the centre on a 0.2 whole time equivalent.

The person in charge reported to the sector manager, who was also assigned as a person participating in management in the centre. This individual reported directly to the director of services, who reported to the board of directors. At the time of the inspection, the person in charge and the person participating in management were on annual leave. There was evidence that measures had been put in place to ensure that effective oversight was in place during these staff members' planned leave. The

person in charge did make themselves available on the day of the inspection, once they had been informed by staff members that the inspection was taking place.

There were nine staff members who worked in the centre. Five of these staff members were employed on a permanent basis, while four staff worked in the centre on a relief basis. It was also noted that seven day service staff had been relocated to the centre, to support residents during the day as day services had not recommenced due to the COVID-19 pandemic.

The inspector met with a number of staff members throughout the inspection. One staff member spoken with was a permanent staff member, who had been on a sleepover shift. Two other staff were relief staff who had been redeployed to the designated centre from the organisation's day services. One of these staff worked three days a week in the centre, the other staff member had only worked there on a couple of occasions.

The inspector reviewed the designated centre's rota, and noted that the staffing levels were in line with the designated centre's statement of purpose. However, it was not evident if the night time staffing level was sufficient, in line with the assessed needs of the residents. One staff member was on duty on a sleepover shift each night, providing support to all four residents living in the centre.

The inspector reviewed evidence of a night-time simulated fire drill that was completed. One resident was not present for the drill as they were at home with their family at the time this was completed. It was noted that it had taken five minutes to safely evacuate three residents from the centre. There was no evidence that this had been deemed a safe evacuation time for the evacuation of all residents from the designated centre.

An annual review of the quality and safety of the services provided in the designated centre had been completed. However, it was identified that although this referenced the extension to the footprint of the designated centre, it did not identify that this had not been registered with HIQA. It was also noted that there was no evidence of an unannounced six monthly visit report being completed between June 2020 and June 2021.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had not ensured that a full application to register the designated centre had been completed to include an extension to the premises and changes to the layout. This resulted in the designated centre breaching a condition of registration.

Judgment: Not compliant

Regulation 15: Staffing

It was not evident if the night time staffing level was sufficient, in line with the assessed needs of the residents. It was noted that it had taken five minutes to safely evacuate three residents from the centre, during a night time simulated drill. There was no evidence that this had been deemed a safe evacuation time for the evacuation of all residents from the designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had not ensured that management systems were in place to ensure that the service provided to residents was safe and effectively monitored. As a result of the evidence in this report, and given the number of not compliant findings identified during this inspection, it was not evident that the registered provider could ensure the effective governance, operational management and administration of the designated centre.

Judgment: Not compliant

Quality and safety

Although residents appeared happy with the supports they received in their home, significant improvements were required to ensure that residents received a safe service.

It was decided that as a result of the serious findings under regulation 28 fire precautions, that the planned unannounced inspection would be changed to a risk based inspection. As a result, the inspector completed an in-depth review of the fire safety management systems in place in the designated centre. A number of issues were identified;

- Night time fire evacuation protocols outlined the requirement to use fire exits that were blocked on the morning of the inspection.
- Staff members on duty were not aware of the manual communication signs that were required to support one resident to evacuate in the event of a fire, in line with their personal evacuation plan.
- The floor plans referenced in the designated centre's fire procedure, and on display in locations throughout the centre to outline the nearest fire exits did not accurately reflect the footprint of the designated centre.

- Staff members on duty had not participated in a fire evacuation drill in the designated centre.
- Two fire drills were completed in 2020. This was not in line with the fire procedure in the designated centre which outlined that four fire drills must be completed each year (one every quarter).
- Weekly fire safety check was not completed the week before the inspection was carried out.
- Three staff members had not received refresher fire training.

It was noted that the registered provider did put measures in place to ensure that a number of these issues were rectified before the end of the inspection.

A fire audit had been carried out in May 2021 by the person in charge. It was evident that the issue of intumescent stripping missing from three doors had been identified as an issue at this time. Although the person in charge had sought updates on when this work would be completed, there was no evidence of an assessment of the risk of this outstanding work, and the controls put in place to mitigate the risk to resident until the issue was rectified. The intumescent stripping was replaced on the day of this inspection.

In line with the designated centre's safety statement, a first aid kit was available in the office in the designated centre. The inspector checked the contents of the first aid kit and noted that items required in an emergency situation had passed their expiration date. For example, some bandages had expired in April 2019 while the burn spray expired in March 2020. The social care leader purchased a new first aid kit, and replaced the first aid kit before the end of the inspection.

The designated centre had recently purchased a new car that residents could use. This vehicle was shared with all four residents. It was evident that the vehicle was roadworthy, and that it suited the needs of the residents that lived in the centre.

A number of measures had been put in place to protect residents in response to the COVID-19 pandemic. Staff members wore face masks at all times, and alcohol hand gel was available in various locations throughout the centre. The designated centre had a stock of personal protective equipment (PPE) in the event this was required. A contingency plan had been developed by the registered provider, which was specific to the procedures to be enacted in the centre. However, on occasions resident temperature checks were not taken twice each day as required by the registered provider.

Regulation 17: Premises

The design and layout of the designated centre was not in line with the statement of purpose. There was not enough suitable storage in the designated centre.

Judgment: Not compliant

Regulation 26: Risk management procedures

Following a fire audit in May 2021, issues which would affect the containment of fire were not addressed in a timely manner. While these works were awaited, there was no evidence of an appropriate risk assessment in place to ensure control measures were in place to mitigate the risk.

The contents of a first aid kit, which was referenced in the designated centre's safety statement had not been reviewed to ensure that the emergency equipment contained in it were safe for use. Although this was rectified on the day of the inspection, it was not evident that effective systems were in place to ensure the monitoring and review of the centre's plans to respond to emergency situations.

Judgment: Not compliant

Regulation 27: Protection against infection

A contingency plan had been developed by the registered provider, which was specific to the procedures to be enacted in the centre. However, on occasions resident temperature checks were not taken twice each day as required by the registered provider.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Under this regulation the provider was required to address an immediate risk that was identified on the day on the inspection. The manner in which the provider responded to the risk did provide assurance that the risk was adequately addressed.

A number of significant issues were identified which impacted on the containment of fire and smoke, access to means of escape, evacuation of residents and staff

awareness of the procedure to be followed in the event of a fire.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and 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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for No.5 Fuchsia Drive OSV-0004577

Inspection ID: MON-0034059

Date of inspection: 24/08/2021

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: 1. An application to Vary the Conditions of Registration has been submitted to HIQA Registration offices on 31 August 2021. This has set out the alterations to the second apartment in the Centre to become self-contained. 2. The Provider has reviewed the systems in place that should have triggered a review of the footprint registered with the Authority and there are a number of additional safeguards now in place to minimise the risk of recurrence i.e. a. A Building Compliance Checklist is completed for all building works and this checklist will include i. Checks against registered footprint of the Centre. This checklist to include steps to ensure proposed building works are subject to relevant permission of the Authority in advance of the building works taking place and on completion of the works. The Building Compliance report completed by the Facilities Manager with updated floor plans are to be notified to Provider Office for sign off prior to commissioning the use of any alterations. The Provider will again at that stage ensure that the completed works are in line with the registered footprint. ii. Checks to ensure that the revised floorplans are held in the Centre and especially in Emergency Fire folder. b. At the annual review of the Statement of Purpose the Person in Charge will be asked to specifically confirm that there is no change to the layout of the Centre. c. At the Six Monthly Provider Visit the Provider will specifically check that the floor plans in the Statement of Purpose and the Fire folder are in line with the footprint of the Centre and notify all discrepancies to the Provider. d. The Provider Designated Centre Registration office now has a log of Outstanding Registration issues to ensure items carried forward are closed off on a timely basis.	
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
1. A night time fire evacuation has been undertaken with one staff member and full capacity four residents on 06/09/21 with a timeframe of under four minutes. This has been observed and reviewed by a competent person and deemed a safe evacuation time given the compensating measures in the Centre i.e. fire rated doors etc.
Further evacuation drills are scheduled under the guidance of the competent person as ongoing training for residents and staff and to target reducing evacuation time further where possible.

2. We have requested a review of the staffing levels against the support needs of the residents and the risk was notified to the HSE on 23 September 2021.
The night time routines and sleep patterns of residents is currently being reviewed for the three full time residents and the part time resident. This review is being conducted by the PIC and PPIM to ensure that the residents support needs are being met. All concerns in this regard will be risk assessed and elevated where necessary to the Provider for action.
Should the Centre warrant a change in night time supports, the Provider will ensure that risks are managed by providing the appropriate staff resources or implement an alternative solution as may be agreed with the Health Service Executive (HSE) as a solution to the residual risk.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Provider has ensure that there is a systematic approach to review of regulatory compliance in the Centre throughout the year. These will lead to themed approach to systems review through the year and will supplement the information gathered at 6 monthly provider visits to the Centre.
2. The Person in Charge will be commencing use of the HIQA fire safety audit tool in September 2021. This will be complemented by the remaining systems in place such as daily, weekly, monthly and quarterly checks on fire related matters. Any findings will be addressed immediately. Fire safety will remain as it has been an agenda item at monthly staff meetings.
3. The provider will ensure a six month audit is conducted as per the regulations. The Quality Department coordinates the unannounced six month audits within each designated Centre and will support with ensuring six month audits takes place as required.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The patio door in one resident's bedroom will be replaced with a single exit door, allowing extra wall space for storage. Once works completed a re-configuration of the bedroom can take place maximizing storage space. Timeframe indicated by contractors given their availability is February 2022

2. A steel shed will be erected for the storage of one resident's belongings to include a display area for their hobby collection. Timeframe indicated by steel shed suppliers is February 2022

3. The mal odour from the bathroom has been investigated and addressed [24/09/2021]

4. The flooring will be replaced in one resident's bedroom as planned to rectify issue of mal odour. [30/11/2021]

5. Bathroom light fixture to be replaced in main bathroom. [31/08/2021]

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Provider has ensured that the PPIM and the Person in Charge have scheduled a Team Meeting to focus on Risk Management. This meeting took place on 21 September 2021 and all of the issues or non-compliance were discussed at this meeting. The Person in Charge ensured that all Team members are clear on risk identification and assessment especially on core issues such as Fire Risks, Infection Control, Infection Control, Safety issues etc.
2. The Person in charge to ensure risk assessments are completed for any outstanding works with control measures in place to mitigate risk.

3. A first aid checklist is in place, to be completed monthly. Any expired products will be replaced as identified in the monthly first aid checklist. This will be discussed at monthly staff meetings.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Provider has ensured that the Organization's Infection Control procedures especially the standard precautions in relation to COVID19 risks are in place in the Centre. The Person in Charge has reminded staff at the risk management meeting on 21 September that that the COVID19 Guidelines and Guidance Sheets in the Centre should be implemented in full and will undertake temperature checking of residents' temperature as part of COVID19 screening least twice daily or more frequently if necessary.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The compliance with the Services internal controls in relation to Fire Safety has been reviewed and the Provider has ensured that the following actions have been put in place.
• Any door wedges in use have immediately been removed and staff have been advised that door wedges are not to be used under any circumstances. The rational for this has been fully explained to staff members.
• The staff team has been advised that in addition to the weekly fire check, they are required to do visual checks on daily basis to ensure no obstructions to fire escapes routes which cannot be tolerated in the Centre. The importance of the Fire Doors as a key risk mitigation factor has been reiterated to the Team.
• The Person in Charge will carry out regular fire compliance audits
• That all staff members will be trained in communication signs in relation to fire in line with one residents' personal evacuation plan.
• That updated floor plan is in place which outlines the nearest fire exits.
• Day service staff that operate from the centre will be asked to participate in fire drills.
• The Person in Charge will ensure that four drills are completed annually to include one night time evacuation. In 2021 there had been 5 completed so far.
• That the Person in Charge will ensure that the weekly fire check is completed.
• That the Person in Charge will ensure that all staff including day service staff operating from the centre have completed fire training.
• All fire doors now have intumescent seals in place and the weekly fire checklist clarifies for staff can monitor that these remain effective.
• Automatic door closure will be fitted to the door in utility room.
• All issues raised will be discussed at monthly staff meeting and fire safety will remain an agenda item at these meetings.
• Fire compliance will remain a prominent area for examination for Provider 6 monthly visits to the Centre

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 5(1)	A person seeking to register a designated centre, including a person carrying on the business of a designated centre in accordance with section 69 of the Act, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	30/09/2021
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of	Substantially Compliant	Yellow	30/10/2021

	the designated centre.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	28/02/2022
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	28/02/2022
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	08/09/2021
Regulation 23(2)(b)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall maintain a copy of the report	Substantially Compliant	Yellow	08/09/2021

	made under subparagraph (a) and make it available on request to residents and their representatives and the chief inspector.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	08/09/2021
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	08/09/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in	Not Compliant	Orange	31/10/2021

	place.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	08/09/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	24/08/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	08/09/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	08/09/2021
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	Substantially Compliant	Yellow	31/10/2021

	fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	08/09/2021