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:	Abbey Village Group Homes
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	31 January 2023 and 01 February 2023
Centre ID:	OSV-0005250
Fieldwork ID:	MON-0037805

About the designated centre

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

Abbey Village Community Group Homes provides full-time residential care and support to fifteen adults (male and female) with a disability. The designated centre comprises of three, five bedded bungalows. Residents in each bungalow have their own bedrooms and also have access to communal living rooms, kitchen dining rooms and bathroom facilities. The centre is located in a residential housing estate in a rural village and is close to local amenities such as shops and cafes. Residents are supported by a team of nurses and health care assistants, with staffing arrangements in each bungalow being based on residents' assessed needs. Abbey Village Community Group Homes aims to provide residential services where each resident is cared for using person-centred planning in close partnership with the resident, carers and families thus empowering each resident to live life to the full within the community in which they live, encompassing social, emotional, spiritual and financial development and independence.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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 31 January 2023	14:20hrs to 18:30hrs	Angela McCormack	Lead
Wednesday 1 February 2023	09:45hrs to 13:20hrs	Angela McCormack	Lead
Tuesday 31 January 2023	14:20hrs to 18:30hrs	Eilish Browne	Support
Wednesday 1 February 2023	09:45hrs to 13:20hrs	Eilish Browne	Support

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor compliance with the regulations. Abbey Village group homes comprised three houses that were located in close proximity in a housing complex. Each house could accommodate five residents.

On arrival to the centre on the first afternoon of the inspection, inspectors were greeted by one staff member who reported that they were the staff in charge on shift and who guided inspectors through hand hygiene requirements and asked inspectors to sign in as visitors. Shortly after the person in charge arrived. Inspectors were informed that one resident who was receiving palliative care had died two days previous. The person in charge spoke about how this resident had been supported in their last few days. They spoke about the arrangements for the funeral, and explained that some residents and staff would be attending this the following day. It was agreed that one inspector would visit this house for a short period as long as the residents were happy for this to occur.

The inspection was carried out over two half days and throughout the inspection a number of staff and 11 residents were met with. Some residents chose to interact and talk with inspectors and some chose not to, and this was respected. Three residents from one house were attending day services external to the house on both days and therefore inspectors did not get to meet them at this time.

From what residents said and from what was observed, it was evident that person-centred care and supports were provided and that residents' health and personal care needs were promoted. Discussions with staff and reviews of documentation also demonstrated a rights based and individualised model of care.

The houses were well maintained, nicely decorated, clean and homely. There were notice boards with information and easy-to-read documents on display. The houses were decorated with photographs and paintings, which added to the homely and warm atmosphere. There were fire containment arrangements in place, however an issue with a fire door in one house required further review. This will be discussed further in the report.

There were accessible garden areas available for residents to enjoy. The gardens were decorated with garden ornaments, bird tables and potted shrubs. Each resident had their own bedroom and en suite facility and there were communal areas for residents to relax and receive visitors. Some residents' bedrooms were observed, and they were found to be nicely decorated and personalised with soft furnishings and framed photographs. Residents had access to televisions and music players in their bedrooms and some residents had their own technological devices which they were observed using during the inspection.

An inspector met with five residents in one house on the first evening of inspection.

Residents were observed freely moving around their home or relaxing in the kitchen with staff and peers. One resident was observed caring for their pet rabbit out the back garden, and they spoke with the inspector about this. Another resident was eating their dinner at the table and they interacted with the inspector in their own way. They had attended the barber that morning and appeared well groomed and relaxed. Residents spoke about the recent weather describing about how the heavy snow that they had recently meant they couldn't go out and about as much. Some residents spoke about how they enjoyed music and going out for meals. When asked, residents said that they liked to get out and about doing activities, and that they were supported with this. Some residents spoke about the death of their friend in one of the other houses and staff described about how they had reminisced about old stories earlier that day. One resident was supported to tell a funny story from a few years previous that involved them and their friend who had died. Some residents said that they had chosen to attend the funeral the next day.

One resident was attending a day service that day, and the inspector met with them on their return. They spoke about what they did during the day and they appeared happy and relaxed in the house. A staff member who had attended a meeting that afternoon in relation to the resident was observed speaking to them about it.

One inspector visited the house in which the resident has passed away two days prior to the inspection. The inspector met with four residents in this house. The inspector was conscious that this was difficult time for both residents and staff and was respectful of this throughout the inspection. Residents were observed to be comfortable in their environment and moved freely throughout their home. When the inspector arrived in the house two residents appeared to be content sitting at the kitchen table and one resident was enjoying their favourite activity of colouring. Previous artwork completed by this resident was proudly displayed in the sitting room. The inspector met with another resident when they returned from day service. They reported that they felt safe in their home and enjoyed living with their peers in the house. It was clear through observation and communication with staff that they were knowledgeable of the care and support needs of residents. In the evening, two residents were observed relaxing in the sitting room. The lights in the sitting room were dimmed providing a calm and relaxed environment for the residents. The other two residents went out for a spin on the bus with the support of staff during the evening.

Inspectors met with two residents in another location. Both residents had chosen not to attend a day service and they were supported to do preferred activities from their home. One resident met with showed inspectors some art work that they had created and they spoke briefly about family visits that were due to occur later that week. Inspectors were informed that family contact was a very important part of residents' lives and that many residents regularly visited, and received family visitors to their home. The provider's annual review included consultation with families; however only consulted three representatives as part of the feedback sought and this required improvements.

Residents also had access to telephones and technological devices to telephone and video call with friends and family. One resident was having a lie in on the morning

of inspection, which was something they were reported to enjoy. Inspectors met them briefly later in the day and while the interaction with inspectors was limited, they were observed to be happy and content and freely moving around their home supported by staff.

Residents were consulted about the running of the centre through regular house meetings. One house meeting reviewed showed a reflective discussion about each resident's highlights of the previous year and discussed if there was anything they would like to achieve in the coming year. It was noted that some residents described the resumption of visiting family and going out for meals after the COVID-19 restrictions as important highlights for them in 2022.

It was evident that residents were supported to make everyday choices that affected their lives, such as choosing meals, activities and whether they attended day services or not. Where residents had particular healthcare needs and dietary requirements, there was evidence that they were supported to learn about their condition and that there was ongoing education about this so that healthy choices may be made.

In addition, residents had personal plans where short-term and long-term goals were set for the year. Residents enjoyed a range of activities such as going on hotel breaks, attending music concerts, visiting tourist attractions, getting beauty treatments, going out for meals and shopping trips.

Staff spoken with appeared very knowledgeable about residents and their support needs. Interactions were observed to be respectful, kind and caring and residents appeared comfortable with staff and supports given. Residents, in general, were supported with familiar staff which helped to ensure consistency of care. However, some staff vacancies were in progress and some staff training was required to be completed in line with the provider's schedule, and this will be discussed in the next section of the report.

Overall, inspectors found that Abbey Village group homes provided person-centred care and support and observations were that residents appeared happy and content in their homes.

The next sections of the report describe the governance and management arrangements and about how this impacts on the quality and safety of care and support provided in the designated centre

Capacity and capability

Overall, inspectors found that Abbey Village group homes had a robust governance and management structure with good arrangements for oversight. Some improvements were required in staffing, staff training and fire safety, which would

further enhance the good quality of care and support provided.

The person in charge worked fulltime in the centre. They reported to a director of nursing (DON). They were supported in the operational management of the centre by a clinical nurse manager 1 (CNM1), both of whom were met with throughout the inspection. The centre was staffed with a skill mix of nurses and care assistants, and in general there was a consistent staff team working. Where additional staff were required for the changing needs of residents, this had been put in place. Agency staff were utilised to cover staffing gaps and in general, a regular cohort of staff were used to help with consistency of care. However, a vacancy for a staff nurse and care assistant remained and while inspectors were informed that this was in progress, this required completion to further ensure that the skill mix of staff was in line with the assessed needs of the service.

The provider had in place a list of mandatory training to be completed by staff and which had set intervals for refresher training to occur. A review of the training matrix for permanent staff and agency staff found that there were significant gaps in training and this required review and a clear plan of action so that mandatory training would be completed in a timely manner.

There was an annual audit schedule in place which included a suite of audits in areas such as finances, medication, complaints, fire safety and health and safety. In addition the person in charge completed monthly reviews of incidents that occurred, which included a review of trends and the assignment of actions as relevant. From a review of a sample of audits and incident reviews, it was found that the person in charge submitted all required notifications to the Chief Inspector as required in the regulations. In addition, the provider ensured that unannounced six monthly visits occurred and that an annual report of the quality and safety of care and support was completed. Some improvements were required to ensure that all residents and their representatives were given the opportunity to give feedback on the service.

The provider had implemented a range of governance meetings during 2022, to help ensure ongoing monitoring of centres and to share learning. The person in charge spoke positively about the impact of some of these meetings, saying that they supported them in doing their role. These meetings included person in charge meetings, bi-monthly meetings with the DON, quality and patient safety meetings and safeguarding meetings. In addition, the provider had implemented a 'Human Rights committee' and a number of meetings had occurred since the last inspection.

The centre had a quality improvement plan (QIP) which included actions arising from inspections, provider audits, and risk assessments. In general, this was found to be comprehensive and keep under ongoing review for progress. However, it did not include an action required to address a fire door issue that had been identified locally. This issue had been identified in 2020, and while some actions were taken to try to address this, this issue remained and required completion. In addition, some improvements were required in local staff meetings, to ensure that these occurred regularly, and that all staff members got an opportunity to participate and raise concerns about the quality of care and support provided.

In general, the governance and management of the centre was robust; however some improvements were required to ensure timely responses to staffing gaps, staff training and oversight of some aspects of fire

Regulation 15: Staffing

A planned and actual staff rota was in place which was well maintained and accurate as to who was working on the days of inspection.

There were two staff vacancies which were reported to be in progress for recruitment, and these were required to be completed to enhance the consistency of care provided to residents and to ensure that the service was staffed in line with the assessed needs of residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

On review of the training matrix, a number of training gaps were identified.

- Nine staff had never completed the fire safety training while a further two staff required the fire safety refresher training.
- Five staff required training in safeguarding, two of which were rostered to work the week of the inspection.
- Training was also required for some other staff in behaviour management, manual handling, hand hygiene, Infection prevention and control basics and standard precautions.

Judgment: Not compliant

Regulation 23: Governance and management

There was a good governance and management structure in place, with clear roles and responsibilities for members of the management team. However, some improvements were required as follows;

- To ensure that all residents and their representatives were consulted as part of the annual review of the service, and given the opportunity to choose if they wished to provide feedback on the quality of the service. For example; the annual review included consultation with three out of 15 family representatives only, despite inspectors being informed that residents had

very good family contact.

- To ensure that all staff members had an opportunity to raise concerns about the quality and safety of care through regular attendance at team meetings.
- To ensure that actions identified locally for fire safety were appropriately followed up and included as part of the QIP.
- One resident's healthcare plan required review to ensure that the system for monitoring aspects of healthcare were completed or reviewed as to whether this remained relevant or not.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A review of incidents that occurred in the centre demonstrated that all notifications were submitted to the Chief Inspector, as required in the regulations.

Judgment: Compliant

Quality and safety

Inspectors found that residents were provided with care and support that was person-centred and to a good quality. The ongoing monitoring by the management team ensured that residents' assessed needs were kept under regular review and that these were responded to, as relevant. However, some improvements were required in fire safety in some of the houses.

There were comprehensive assessments of needs completed for each resident to assess their health, personal and social care needs. There were up-to-date care plans in place where the need was identified. Annual review meetings were completed for residents and which ensured participation with residents and their representatives, as appropriate. Residents were supported to identify and achieve personal goals for the future.

In addition, each resident was supported with their healthcare needs and were provided with information about healthcare to support them with making choices. Healthcare needs were kept under regular review and residents were supported to access the services of allied healthcare professionals and multidisciplinary team (MDT) members. One resident had been referred for speech and language input, and this was kept under review for completion. One healthcare plan required review as a monitoring chart that staff were to complete was not completed in January. On discussion with staff, it was explained why this had not been completed; however this required further review to ensure that the need for this chart was reviewed and

the care plan amended as appropriate. This action is covered under governance and management.

Residents who required support with behaviours of concern had comprehensive plans in place which clearly outlined behaviours and the proactive and reactive strategies to support with this. This included MDT input. On the first day of inspection, one resident's supports were reviewed with a specialist in behaviours, and staff reported this initial consultation with this specialist to be very beneficial.

There were a number of restrictive practices in place for safety reasons and these were kept under regular review and were assessed to ensure that they were the least restrictive option. The person in charge included auditing of restrictive practices as part of the schedule of audits in the centre and these were found to be completed in line with the schedule.

Safeguarding of residents was promoted through staff training, ongoing review of incidents and the adherence to the safeguarding procedures. It was found that negative interactions between residents were followed up through the safeguarding procedures to establish if there were grounds for concern or not. Where safeguarding plans were required, these were in place and kept under regular review. There was a safeguarding tracker log, which recorded safeguarding concerns and the status of them. This demonstrated good monitoring and oversight by the management team.

Residents were supported to understand about keeping safe and there were a range of easy-to-read documents to aid understanding of topics such as abuse and complaints. In addition, the provider had recently implemented a policy on safe internet usage, and this had been read and signed by all staff. The policy included an easy-to-read version for residents to support with understanding. The staff nurse in one house said that this policy was due to be explained to residents at the next resident meeting.

There were risk management policies and corporate and site specific safety statements in place. Each resident had been assessed for risks to their safety and wellbeing, and care plans and assessments were developed where required. The centre had a risk register which was found to be comprehensive, up-to-date and included risks for the centre. However, inspectors found that the fire risk assessment required review to ensure that it was specific to the risks in the centre. In addition, fire drills under the scenario of maximum residents and minimum staffing was required in one house, to ensure that all five residents, which included wheelchair users, could be safely evacuated with the minimum staffing levels.

In summary, inspectors found a service that was well governed and that ensured residents were supported with their assessed needs. Some improvements as discussed throughout the report would further enhance the good care provided.

Regulation 10: Communication

Residents in the centre were supported and assisted to communicate in accordance with both their needs and wishes. Staff were aware of the different communication needs of residents. A communication document observed for one resident highlighted the words they frequently used and how they signed them. It was evident that staff were familiar with these signs and their meanings through observation on the day of inspection. Residents also had access to many forms of media including radio, television and many residents had technological devices and mobile phones.

Judgment: Compliant

Regulation 26: Risk management procedures

Overall, the risk management procedures, including the assessment and review of risks were good. However, the fire risk assessment required review to ensure that it was updated to include an assessment of all the current risks in the centre and that it was specific to the locations in the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety arrangements in this centre required improvements. The registered provider failed to identify that a fire door in one of the houses required repair on the quality improvement plan (QIP) The issue with the fire door was first identified in 2020, and while some actions were taken to try to address this, the fire door still requires repair.

A fire drill under the scenario of minimum staff and maximum residents was required to be completed in one house, to ensure that all residents could be brought to a safe location in the event of a fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs were comprehensively assessed and care plans kept under regular review. Annual review meetings occurred which included residents and their representatives as appropriate, and residents were

supported to make personal goals for the future and were facilitated to achieve these goals.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve good health and wellbeing, by being facilitated to access allied healthcare professionals, vaccine programmes and national screening programmes, in line with their wishes and needs. Residents were supported to learn about their healthcare conditions so that they could make informed decisions.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents required supports with behaviour, this was available to them. Behaviour support plans were in place as required, and included a multidisciplinary input.

The person in charge ensured that restrictive practices were kept under ongoing review as to if they were the least restrictive option and proportionate to any risks.

Judgment: Compliant

Regulation 8: Protection

The provider ensured that residents were protected from abuse. Where concerns of a safeguarding nature arose, these were followed up in line with the provider's policy and these concerns were regularly monitored.

Where safeguarding plans were required these were found to be kept under regular review and included consultation with MDT as appropriate to ensure adequate supports were provided to residents.

The provider had recently implemented a policy on safe internet usage for residents and this was being rolled out in the service at the time of inspection.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that residents were provided with person-centred care and support that promoted rights and enabled residents to make choices about how they lived their lives. Many staff had received training in Human Rights and it was evident through talking with staff that residents' rights and choices in their lives were respected.

Where residents required supports and input from external professionals, this was provided.

Regular house meetings occurred which demonstrated that consultation occurred with residents, and residents were supported to make choices in their day-to-day lives.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Abbey Village Group Homes OSV-0005250

Inspection ID: MON-0037805

Date of inspection: 31/01/2023 and 01/02/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In order to bring the centre into compliance with Regulation 15: Staffing the following action has been taken • To ensure consistency of staffing within the centre, two care assistant posts have been approved; · One Care Assistant due to commence employment in the centre on the 27/02/2023 · The second care assistant post has gone out to the panel and a start date will follow through accordingly once clearance has taken place. Completion date : 31-05-2023	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: In order to bring the centre into compliance with Regulation 16: Training and staff development the following actions will be undertaken • Refresher Fire Training – Two staff required this training and have completed same on the 23-02-2023 Fire training – Nine agency staff require this training. Training has been scheduled for 07/03/2023. Completion date 30-03-2023	

• Safeguarding Training – five staff required this training, 3 agency staff and two HSE care assistants. All five staff have completed this training on the 24-02-2023

• Positive Behaviour Support Refresher Training for one HSE staff is scheduled for 03-03-2023.
Positive Behaviour Support Training – 14 agency staff require this training. Training has been scheduled for the 14/03/2023, 15/03/2023, 22/03/2023 and 23/03/2023 for x14 Agency staff. Completion date 30-04-2023.

• Manual Handling – 5 agency staff require this training and training dates have been schedule. Completion date 20-03-2023

• Hand Hygiene – 2 HSE staff require this training. This training was completed on HSELand on 10-02-2023.
6 Agency staff require this training on HSELand. Completion date 01/03/2023

• Infection Prevention –3 agency staff required this training on HSELand and completed same on the 24-02-2023

• Control basics and Standard Precautions – 3 agency staff required this training on HSELand and completed same on the 24-02-2023

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In order to bring the centre into compliance with Regulation 23 Governance and management the following actions will be taken.

To ensure all residents and their representatives have an opportunity to provide feedback on the quality of services the following actions will be undertaken:

1) A sample of residents and their representatives will be contacted as part of the Provider Nominee Visits to the centre.
2) The remaining residents and their representatives will be contacted for the annual review of the service, this will ensure that residents and families provided with an opportunity to provide feedback on the quality of the service.
3) Every six months residents are encouraged and supported to complete the satisfaction questionnaires with findings use to inform improvements required for care provision and delivery

• The PIC has developed a schedule for local governance meetings for each of the houses for 2023.

1) The agenda for the local governance meetings will be displayed in each of the houses two weeks prior to the meeting occurring. The will afford staff the opportunity to add to the agenda as required
2) Where a staff member wishes to raise a concern regarding quality of care however cannot attend the local governance meeting, all staff member have been advised that they can link with the PIC directly to voice any concerns regarding the quality of care.
3) The PIC will ensure that a copy of all local governance meetings are available in each of the houses and ensure minutes from the meetings are read and signed by each staff.

• The PIC has updated the centres fire risk assessment to reflect maintenance required for one fire door on the 02/02/2023.

• The PIC contacted the Housing Association on the 02/02/2023 regarding the maintenance work required for one fire door.

• The maintenance required for the fire door to ensure fire compliance has been added to the center Quality and Improvement Plan on the 02/02/2023.

• Fire door repaired on the 03/02/2023.

• The healthcare plan for one resident has been reviewed and updated to ensure it reflects the needs of the resident on the 10/02/2023.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In order to bring the centre into compliance with Regulation 26 Risk Management the following actions were undertaken

• The PIC has updated the centres fire risk assessment to reflect maintenance required for one fire door in the centre on the 02/02/2023.

• The PIC contacted the Housing Association on the 02/02/2023 regarding the maintenance work required for one fire door.

• The maintenance required for the fire door to ensure fire compliance has been added to the centers Quality and Improvement Plan on the 02/02/2023

• Fire door repaired on the 03/02/2023.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In order to bring the centre into compliance with Regulation 28 Fire Precautions the following actions have been undertaken

• The PIC has updated the centres fire risk assessment to reflect maintenance required for one fire door in the centre on the 02/02/2023.

• The PIC contacted the Housing Association on the 02/02/2023 regarding the maintenance work required for one fire door.

• The maintenance required for the fire door to ensure fire compliance has been added to the center Quality and Improvement Plan on the 02/02/2023

• Fire door repaired on the 03/02/2023.

• Fire drill completed with a minimum of staffing and maximum residents in one house. The fire drill has been recorded in the centres Fire Register. Completion date: 22/02/2023

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, 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 the designated centre.	Substantially Compliant	Yellow	30/04/2023
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.	Not Compliant	Orange	30/04/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	30/12/2023

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/12/2023
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	30/12/2023
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.	Substantially Compliant	Yellow	30/12/2023
Regulation 28(2)(b)(ii)	The registered provider shall make adequate	Substantially Compliant	Yellow	07/03/2023

	arrangements for reviewing fire precautions.			
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.	Substantially Compliant	Yellow	07/03/2023