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:	The Anne Sullivan Centre
Name of provider:	The Anne Sullivan Centre CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	10 August 2022 and 11 August 2022
Centre ID:	OSV-0001388
Fieldwork ID:	MON-0028378

About the designated centre

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

The centre was established specifically to meet the needs of people who are deafblind. The centre provides a residential service to 13 male and female residents. The centre comprises of four houses in a residential cul-de-sac of a suburb of Dublin. There are also two apartments located in an adjacent building. The centre is located a short distance from a range of shops, restaurants and public transport options. Each of the residents has their own bedroom which has been personalised to their own tastes and support requirements. A number of the residents have their own kitchen and living room area while other residents share these areas. There was a communal garden area and walkway around the centre and each of the houses has their own garden to the back of the properties.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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
Wednesday 10 August 2022	10:00hrs to 18:00hrs	Gearoid Harrahill	Lead
Thursday 11 August 2022	10:00hrs to 13:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

During the two days of this inspection, the inspector had the opportunity to meet 12 of the 13 residents living in the designated centre. As this inspection was announced to residents in advance, the majority of the residents completed surveys in which they described what they liked about their home, where they would like things done differently, and their satisfaction with the staff team, their routines, meals, outings and access to interesting opportunities.

Residents in this service were deafblind, and the front-line support team supported the residents and inspector to communicate with each other using tactile communication methods and sign language. Residents told the inspector what they had planned for their day, and events and outings they had recently been on or were going to soon. It was a hot and sunny day during the inspection and many of the residents enjoyed relaxing in the sun, on the grass or in their garden furniture. Staff ensured that residents were provided screens and sunblock before sitting outside for a long time. Other residents were listening to music, relaxing with sensory items, and getting ready to meet with family. Residents came and went throughout the inspection, going to the barber, going out for coffee, clothes shopping, swimming, or out for walks with staff. As all residents were supported by allocated staff members, their routines were generally uninterrupted by those of their peers as residents could come and go freely by foot or by vehicle. There were also nearby public transport options.

Throughout the inspection, the inspector observed fluent use of different communication methods by the staff members to support residents to make choices, plan their day and chat together. This included textiles and props which the resident used to identify people, choose what they wanted to do, and express their feelings. Staff also used Irish Sign Language to speak with residents and allow residents and the inspector to speak with each other. One resident had recently acquired a specialised device for communicating, as well as browsing the internet and sending emails, and staff were being facilitated with training to support the resident to use the device. Staff were always available and within arms reach to support the deafblind residents and reassure them that they were nearby. Staff members met and spoken with had a very friendly and positive rapport with the residents, and were observed protecting their privacy and dignity. Residents were comfortable around staff and there was a casual and relaxed atmosphere in the house.

Each resident had a single private bedroom and suitable access to living, kitchen, bathroom and garden areas. The premises was suitably laid out to allow residents to traverse the grounds on foot, with staff or using a mobility scooter. Guide rails, ramps, a stair lift, Braille signage and safety padding were also used to support safe navigation and reduce the risk of trips or injuries.

Following the social restrictions implemented during the COVID-19 pandemic, some of the residents had become used to their lives being less busy. The inspector

observed good examples of staff encouraging the residents to get back to what they enjoyed outside of the centre, or find new opportunities they may enjoy. Some residents attended educational classes, and some were engaged in paid employment.

One resident had recently given a presentation to the board of directors of the company, in which they described their experiences in the house, as well as speaking on behalf of their peers. Residents in another house were similarly advocated for by one of the house leaders who showed the board pictures and commentary from the residents' activities and projects on their behalf. The inspector found evidence of the residents being involved with and having their input sought in audits, service reviews and staff recruitment and probation processes.

The next two sections of the report 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 delivered.

Capacity and capability

The provider had comprehensive governance arrangements in place to effectively manage this designated centre and oversee the quality of resident support. Some review was required in the provider's oversight of the accuracy and completeness of records in the service, and in how the provider is assured that staff have the required skills for the residents they may be supporting. However, in the main, the inspector found evidence to indicate that the provider was striving for regulatory compliance and continuous service improvement.

The designated centre was registered until December 2022, and the provider had submitted their application with all required information to renew the centre for a further three years. The purpose of this inspection was to assess compliance with the regulations and to inform the decision on whether to renew the registration of the centre.

The provider had conducted their annual and six-monthly reports on the quality and safety of the service, as well as a programme of ongoing audits, to identify and set out plans to address service deficits, areas for development and potential future concerns. The service was led by a person in charge who was clear on their role and responsibilities under the regulations, with suitable deputation structures in each of the locations which made up the designated centre.

The inspector found that staff had a good knowledge of the residents, their histories, personalities, preferences and support needs. Staffing resources and allocation were sufficient to ensure that staff were supported in accordance with the statement of purpose and in a manner which was suitable for the number and routines of residents. Staff were up to date in training required under the

regulations, however there were some deficits in staff training on residents' support needs, including among staff who are not typically allocated to the residents in question. The inspector reviewed a sample of records for team meetings, supervision sessions and probation reviews and found these were carried out in accordance with provider policy.

Some review was required in ensuring that documents related to the personnel, centre and residents were complete and up to date, to avoid instances of conflicting information and staff guidance, examples of which will be referenced later in this report.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted their application to renew the registration of the designated centre, along with the required associated documentation, within the timeframe required by the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced in their role and was aware of their role and responsibility under the regulations.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had an appropriate complement of staffing personnel based on the number of residents and the layout of the houses. A sizable relief panel was available who were regularly deployed to the houses to cover absences and holidays. The provider maintained a clear record of the hours and locations worked by all regular and relief staff members.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed a sample of records which indicated that staff were supervised and their performance was managed by their respective line managers in accordance with the provider's policy. New staff members were subject to an appropriate probationary review and evidence was available to indicate goals for career development identified by staff members.

All staff were facilitated to attend training in mandatory areas such as fire safety and safeguarding of vulnerable adults. In a review of other training sessions, a number of regular and relief personnel did not have training required to support residents with specific needs. This included:

- 18% of support staff not trained to administer medicines,
- 32% not trained to use physical interventions as part of positive behaviour support, and
- 8% not trained to support people with a diagnosis of epilepsy.

The provider's policy indicated that any training was required only by staff based in specific houses with those needs. However, in a sample reviewed of worked rosters in the houses, the inspector observed an average of 40 shifts a week worked by relief personnel who were not exclusive to a house, as well as many instances of staff working in houses in which they were not typically based, to cover leave. During the inspection, the inspector identified one resident being supported alone by a staff member who was not trained to meet their assessed support needs. Review of training requirements was needed to ensure that staff had the required skills and competencies to delivery resident support at home and in the community.

Judgment: Substantially compliant

Regulation 21: Records

In a sample of resident support plans reviewed, a number of these plans were overdue for amendment to reflect review notes and recommendations for changes, and to ensure consistency in the delivery of resident care. This included an instance in which the instructions of the multidisciplinary team had not been reflected in the associated support plan, resulting in contradictory information guiding staff.

The inspector reviewed a sample of personnel files for staff, and found that the documentation required under Schedule 2 of the regulations was not complete.

Judgment: Substantially compliant

Regulation 22: Insurance

Appropriate insurance arrangements were in place for this centre.

Judgment: Compliant

Regulation 23: Governance and management

Sufficient premises, personnel, equipment and transport resources were available to ensure the delivery of support for residents.

The provider had conducted their annual review of the designated centre in March 2022 and this incorporated feedback attained from front-line staff members, the residents, and their representatives. Through internal quality and safety audits, as well as externally commissioned reviews of the premises, the provider was proactively identifying areas in need of improvement or further development. Actions for the year ahead were described from these findings.

The provider had sufficient structures in place for the supervision, probation and performance management of staff in the designated centre.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose outlining the services of the designated centre, which included the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider maintained a suite of policies and procedures on matters required under Schedule 5 of the regulations.

Judgment: Compliant

Quality and safety

Throughout the inspection, the inspector observed an overall high quality of care and support delivered by this service. The residents were central in their support structure and decisions made about them, and their rights, dignity and social activation was a key consideration in how support and routines were planned out. Some areas were identified as in need of development, primarily around the consistent and proper recording of medicines, and in work required to the premises to bring it into compliance with fire regulations.

The premises of the centre was suitable in design and layout for the number and assessed needs of the residents. The houses and gardens were equipped with features to support safe navigation around and between the residents' houses. The premises were kept in an overall good level of cleanliness and maintenance, with some minor areas identified for improvement to address damaged paint, plasterwork and furniture upholstery, and areas with heavy dust and cobwebs.

Residents were provided overall unrestricted and unimpeded access in their home and to the other parts of the designated centre. Some improvement was required to ensure that where fire doors were kept open to support this navigation, it was done in a manner which did not compromise their safety features. The inspector observed many fire containment doors being hooked or wedged open around the designated centre.

The provider had commissioned an external risk assessment on fire safety and set out a plan of works to come into regulatory compliance. While these works were still in their initial stages with no identified date of completion of work to protect evacuation routes, actions which could be achieved in the short term, such as replacing damaged smoke seals, were observed to be in progress during the inspection. All firefighting devices, emergency lighting and the alarm system were kept under routine service and maintenance.

Areas for improvement were identified in practices in the administration and recording of medicines in the centre. Review was required in how the provider was assured that residents were routinely receiving their medications as they were prescribed, through consistent staff guidance and instruction, complete and accurate records, and the availability of support staff trained to administer medicines when required.

Residents were encouraged to utilise feedback, complaints and commentary methods to ensure that their voices were heard in decisions made about them or their house, and to ensure they felt safe and respected in their home. Residents, or their representatives, contributed to reviews and changes to their personal support plans, communication profiles and activity planners.

Regulation 10: Communication

Throughout this inspection, the inspector observed a high level of knowledge and

fluency by staff of the communication methods used by deafblind residents. This included use of sensory items, Irish Sign Language, touch communication and assistance equipment to support the residents to communicate, and for others to communicate with them.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were supported to personalise their homes and living spaces in accordance with their preferences and support requirements. Residents had adequate storage for clothes and belongings. Suitable safeguarding measures were in effect for residents who were supported by staff with their finances.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had been supported and encouraged to avail of social, recreational, employment and education opportunities in accordance with their wishes and assessed needs.

Judgment: Compliant

Regulation 17: Premises

The premises of the centre were generally kept in a good state of maintenance, were homely, pleasantly decorated and facilitated residents to safely navigate their environment. Guide rails, Braille signage and clear walkways were used for residents to safely travel on foot or with their mobility equipment. Some minor improvement was required in the cleanliness and paintwork of the houses, including some bathrooms which had unclean ventilation fans, or dust and cobwebs hanging from the ceiling. The upholstery of some furniture was observed to be torn.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector observed examples of where the provider had identified risks in the operation, practices or environment of the service, but had not risk assessed or set out control measures to mitigate same in the centre's risk register. The inspector observed other instances of control measures on the risk register which had not been implemented in practice.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were suitable measures in effect to protect residents, staff and visitors against risk related to infection prevention and control. A suitable bedroom on the premises had been designated for isolation use if necessary. Kitchens, frequently-touched surfaces, areas for storing medication, and equipment such as mops and buckets were clean. Guidance related to community access, visitors, and use of face coverings were in line with the national recommendations for residential health and social care settings.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety equipment such as alarm systems, fire extinguishers and emergency lighting were all in good working order and serviced regularly. The provider had conducted practice evacuation drills to be assured that residents and staff could get to a place of safety in an efficient manner.

In all five residences in this centre, evacuation routes were not sufficiently protected to contain the spread of fire and smoke. Where doors were equipped with fire containment features, these had been compromised by means of smoke seals being painted over, doors being hooked open to walls, or doors being wedged open by door stoppers or using the carpet. Improvement was required to ensure that where residents required or preferred for doors to remain open, that this was done using a means which did not compromise the self-closing features of doors.

However, the inspector was provided with a comprehensive report of an external fire risk assessment which had been commissioned in 2022 to identify works required to come into compliance with the regulations, such as replacing room doors with 30 or 60 minute fire rated doors, replacement of smoke seals, and removal of features which may obstruct safe evacuation routes. The provider evidenced how they had used this assessment to develop an action plan for each location, and while many items did not yet have an expected date of completion, some of the

short-term actions were being completed at the time of the inspection.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Suitable arrangements for storing, dispensing and disposing of medicines were in place, all medicine was in stock and labelled correctly, and staff were provided with guidance on protocols related to PRN medicine (administered only when required). Where medication errors had been identified, the provider had reviewed any trends in the reasons for same.

The inspector reviewed a sample of resident prescriptions and administration sheets for medicines, and identified some areas requiring improvement in how these records assured the provider that medications were administered in accordance with prescriptions. Examples of observations included the following:

- The inspector observed a substantial number of instances in which medicines were not administered at the time or in the manner prescribed by the doctor.
- Times in which the resident declined their medication were often not recorded.
- Staff spoken with advised that some medicines could be, and routinely were, administered later than the prescribed times on the presumption that the resident would refuse, which was not an appropriate practice and was contrary to the instructions of the prescription.
- Some days on the administration records were left blank, including for the day of the inspection. When raised with staff, the inspector found that for some of the missing days, evidence of administration or refusal was instead recorded in daily handover notes. This is inappropriate practice and had the potential to result in missed or repeated doses.
- Administration records did not clearly indicate what time medicines were administered or refused, using time descriptors such as "breakfast" or "bedtime", making it unclear if medicines were consistently administered at the times prescribed, including instances where different medicines were administered by different people.
- The inspector observed some conflicting information between the time on the prescription sheet and the time on the medicine blister packs.
- Not all staff supporting residents were trained to administer medication, including emergency intervention medicines, resulting in staff working alone having to wait for an authorised staff member to be available.

Development was required in these practices, as well as the provider's oversight of conflicting instructions and records, to ensure that medicines were consistently administered as they were prescribed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' support needs were assessed routinely and as required by the provider, with suitable input from the multidisciplinary team and the resident themselves, or their representative. These assessments were used to inform a detailed, evidence-based support plan, and staff guidance on delivering the residents' care and support needs.

Support plans were written in a person-centred manner, and care and support delivery described in the plans was observed being implemented by a knowledgeable front-line team. Visual aids were used to support staff to understand and use the resident's communication methods. Simple language or sensory or touch versions of the plans were available to residents.

Judgment: Compliant

Regulation 8: Protection

Staff were trained in safeguarding vulnerable adults, and the designated officer had recently run refresher workshops for staff to further develop their skills and knowledge. Staff were aware of their roles and responsibilities in keeping residents safe and responding to alleged or witnessed instances of abuse. Measures were in effect related to safeguarding from financial abuse, and maintaining the dignity of residents with intimate or personal support needs.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider and direct support staff followed practices which allowed residents to have their voices heard in the operation of the designated centre. Examples were observed of resident feedback and commentary being sought and invited in service audits, governance meetings, recruitment processes, the complaints procedure, and event planning. Throughout the inspection, staff interacted with residents in a respectful, dignified and person-centred manner.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Anne Sullivan Centre OSV-0001388

Inspection ID: MON-0028378

Date of inspection: 10/08/2022 and 11/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has reviewed staff training requirements across the organisation with a focus on identifying what is needed to ensure that staff have the required skills and competencies to deliver resident support at home and in the community. • All frontline staff who have not yet carried out stand alone health related training will be required to carry out these modules as a matter of priority. • The Induction programme for new hires will incorporate health related training modules. • The PBS plans have been reviewed. There is a training programme in place to address the gaps pertaining to physical interventions across the organisation.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Person in Charge can confirm that the gap in the documentation identified and required under Schedule 2 of the regulations has since been resolved. Residents' support plans have been fully reviewed and updated to reflect all recommendations of the multidisciplinary team offering greater clarity to staff on how to support a resident with particular health needs. This will be kept under review by the management team.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All residences and associated buildings have been reviewed with reference to cleanliness and upkeep of same. An IP&C audit of the premises has been completed with a focus on addressing the particular issues identified during this inspection.
The PIC can confirm that the issues identified in this inspection report have been fully addressed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The organizational risk register has been reviewed and updated to reflect additional operational risks e.g., medication management. Control measures have been reviewed and new protocols and practices introduced to ensure that all measures are operationalized.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC has engaged the services of independent fire safety experts to inform the organization on how to ensure that Regulation 28 is met as a matter of priority. Some works have progressed further since the date of the inspection others are a work in progress.

To note:
Automatic dorgards are in place in the community houses based on risk assessments and where residents' preferences are that doors are held open. There is weekly testing of fire alarms and the safety of the dorgard system to ensure that residents are not unnecessarily impeded by doors being kept closed/automatically closing.
Door Intumescent strips are being upgraded on all fire doors.
An external contractor will commence all outstanding fire safety works on 29th September 2022. It is envisaged that all works will be completed within one week.

Medium
Some doors in high-risk safety locations (e.g., top of stairwells) are being assessed for the most suitable door closing solution. Residents will need to undertake training/social stories on how to navigate their environment when/if doors are to automatically close or kept closed.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
An external company will complete a comprehensive audit of "medicines and pharmaceutical services" and will provide follow up training on all issues emerging from their audit and this inspection report. This audit is scheduled to take place on October 26th, 2022.

The Residential Services manager has reviewed all medication records and made the following amendments/additions

• When a resident declines their medication (formerly recorded on EPICCARE online record system) – this in now recorded via the residents Medication Administration Record Sheet (MARS)
• The GP has updated the Cardex and prescription to facilitate late administration of medication where appropriate. All MARS recordings now reflect the GP instruction and Cardex.
• Evidence of medication administration/refusal is no longer recorded on the daily handover notes but on the residents MARS.
• The MARS sheet has been updated with specific times to record the exact time of medication administration/refusal.
• Any discrepancies between the information on the prescription sheets and blister packs have now been resolved. This will be kept under review on an ongoing basis.
• A enhanced checklist for medication deliveries has been developed which captures possible issues such as any mismatch between blister pack instructions.
• 'Medication monitors' who are responsible for weekly medication audits are currently being identified for each location.
• A comprehensive staff training plan is being developed to ensure that staff who are working with residents' are appropriately trained in administering emergency health related medicines.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/12/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	27/09/2022
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	27/09/2022

Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	27/09/2022
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	31/12/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2022
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as	Not Compliant	Orange	31/10/2022

	prescribed to the resident for whom it is prescribed and to no other resident.			