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:	St. John of God Kerry Services - Supported Living
Name of provider:	St John of God Community Services CLG
Address of centre:	Kerry
Type of inspection:	Announced
Date of inspection:	16 January 2024
Centre ID:	OSV-0002927
Fieldwork ID:	MON-0033082

About the designated centre

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

The registered provider stated the aims and objectives of the service provided with St. John of God, Kerry Services, supported living is to "enable and empower individuals with an intellectual disability to access, in accordance with their wishes and abilities, the spiritual, social, educational, training and employment opportunities that are available to all residents". This centre can provide accommodation to eight individuals over the age of 18, both male and female, with an intellectual disability. Accommodation is spread over six apartments, two of which are 2 bedrooms. Staffing support is afforded to residents in accordance with their assessed needs. Presently this is through social care workers and the day to day oversight is maintained by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 16 January 2024	10:00hrs to 16:30hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This was an announced inspection in St. John of God's supported living designated centre. The purpose of the inspection was to monitor ongoing compliance with the Health Act 2007 and to assist in the recommendation to renew the registration of the centre for a further three year cycle. On arrival the inspector was greeted by the person in charge of the centre. The inspector was informed that all residents were going about their daily routine. Many residents within the centre attended local day services to which they attended independently.

Each resident was provided with a questionnaires to complete prior to the inspection. These questionnaires provided residents with the opportunity to raise any concerns to the inspector regarding aspects of their life in the centre. All residents who completed these questionnaires, DID SO with the support of staff. In the majority of questionnaires completed, residents noted that they did not wish to meet with the inspector of for the inspector to review their personal plan. The inspector respected this in so far as was possible. Upon review of questionnaires the inspector noted that one resident had concerns regarding their right to make choices and staff interaction. While staff could articulate these concerns and the discussion they had with the resident this had not been documented.

The inspector did have the opportunity to meet and chat with one resident after their return from day service. They chatted happily about their new apartment. They enjoyed their own space but knew they could always call staff if they needed anything. One staff always called over to support them get their tea ready. They were looking forward to relaxing and watching the television for the evening. This resident spoke of their personal goals and how the staff supported them to achieve these goals. At the time of the inspection the resident's main goals was to save money to get to visit their favourite football grounds in England. They were very excited about this. The resident spoke confidently of who they would speak to if they had any worry or concern in the centre.

The inspector did a walk around of some areas in the centre. One vacant apartment visited required attention. A toilet and sink had been removed from a room but pipework and services remained visible. Storage issues highlighted were due to be completed in February 2023, while ordered had yet to be fitted. Areas visited did appear clean and suitably decorated. Residents were supported to decorate their personal spaces in accordance with their own wishes. Some outstanding maintenance work required attention. Also, one resident had requested a self-closing mechanism on their living room door to allow for free movement within their apartment. This had yet to be addressed by the provider.

As will discussed in more detail in the report the registered provider was issued with an urgent action of the day of the inspection. The provider was required to provide assurance with respect to the integrity of all fire doors of the designated centre. This was required to ensure the containment measures in the centre was effective and

safe. 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 the quality and safety of the service being delivered.

Capacity and capability

This was an announced inspection in St. John of God's supported living designated centre. The purpose of the inspection was to monitor ongoing compliance with the Health Act 2007 and to assist in the recommendation to renew the registration of the centre for a further three year cycle. The registered has submitted an application for this renewal incorporating the required prescribed information.

The designated centre had previously been inspected by the Health Information and Quality Authority in February 2023. Following this a compliance plan response had been submitted of actions to be completed and a timeframe for all areas to be addressed as identified. On the day of this inspection it was evident that this plan had not been adhered to. A number of actions remained outstanding including under Regulation 28 and Regulation 17. To provide assurance to the chief inspector the provider was issued an urgent action for Regulation 28 on the day of the inspection. This will be discussed in more detail in the next section of the report.

The registered provider had appointed a suitably qualified and experienced person in charge to the centre. They held remit over two designated centres and reported to a person participating in management. They had an allocation of 50% time to this centre but an on-call system was in place for staff support. There was evidence that the person in charge reported areas of concern to senior management through emails and formal meetings.

The registered provider had ensured the implementation of the regulatory required monitoring systems. This included the annual review of service provision and six monthly unannounced visits to the centre. Following these reviews should any concern or non-compliance arise these were actioned under the provider quality enhancement plan. This plan had highlighted dates for actions to be completed. However, it was noted that should an action not be completed the date was adjusted with no rationale present or escalation to the relevant parties to ensure actions were addressed in a timely manner. For example, actions were identified in previous inspection and again in July 2023 six month unannounced visit regarding the integrity of fire doors. The date for completion was originally set for May 2023. This date was forwarded on numerous occasions with actions still outstanding.

The person in charge also completed on site monitoring to oversee the day to day operations of the centre. This included fire safety, environmental and complaints. While these were consistently completed they were not used to identify areas of non-compliance in all areas, therefore not ensuring required actions were

completed.

Since the previous inspection staffing levels had been reviewed to reflect the assessed needs of residents currently residing in the centre. The statement of purpose had been updated to reflect this change. An actual and planned roster was in place to ensure supports were in place as required. Staff spoken with on the day of the inspection were knowledgeable to the needs of residents and their role with the designated centre.

The registered provider had ensured the development of a complaints procedure. This was further developed in accessible format to ensure the understanding for residents and was visible within the centre. The person in charge reported no open complaints in the centre. As part of documentation review it was noted in resident meetings that when the topic complaints were discussed the same areas was raised on numerous occasion. However, no complaint had been logged to address this area. It was also not clear if the complaints process had been offered to residents at this time, or if staff had raised the complaint on behalf of the residents.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained information as required by the regulations. However, a recent change to the function of a room had not been included in the application. The floor plans of the centre were required to be reviewed and resubmitted.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge of the centre.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection, the registered provider ensured that there were sufficient staffing levels were present to meet the assessed needs of the residents. There was an actual and planned roster in place.

Judgment: Compliant

Regulation 22: Insurance

There was written confirmation that valid insurance was in place including cover in the case of injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to the person participating in management.

There was evidence of quality assurance audits being implemented to ensure the service provided was appropriate to the resident's needs. The quality assurance audits included the annual review of 2022 and six-monthly provider visits. In addition, there was evidence of local audits completed by the person in charge and delegated staff members taking place in the centre. However, there was no evidence that actions identified within these audits were completed within the provider allocated time frame. Also, audits completed did not consistently identified areas of non-compliance to allow for actions to be implemented.

The inspector did not observe or evidence adherence to the compliance plan response submitted following the previous HIQA inspection. Due to this and the ongoing non-compliance in the Regulation 28, an urgent action was issued to the provider on the day of the inspection

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

There was a clear admissions process in place within the centre. This was also set out within the Statement of Purpose. A service user agreement was in place which set out the supports to be provided within the centre and the fees to be charged.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had prepared a Statement of Purpose which contained all of the information as required by Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured the development of a complaints procedure. This was further developed in accessible format to ensure the understanding for residents and was visible within the centre. However, when it was noted in documentation that residents were raising a repeated topic in residents meetings under the remit of complaints there was no evidence of these being addressed in accordance with organisational policy.

Judgment: Substantially compliant

Quality and safety

St. John of God's supported living designated centre was located on the outskirts of a large town. The residents on the day of the inspection were attending their individualised day services and chose not to meet with the inspector. Residents in the centre were supported to attend activities and training programmes as per their interests and hobbies. One resident who did meet with the inspector spoke of their personal goals and how they were saving to head to see their favourite football grounds.

Overall, residents were consulted in the day to day operations of the centre. Weekly resident meetings were held with all residents provided with the opportunity to attend should they wish. Residents could discuss such areas as feel safe and what activities they wished to participate in and what support they may require. While some areas discussed highlighted concern for residents such as ongoing maintenance issues, this was not followed through on as per process. This was discussed under Regulation 34.

Each resident has a tenancy agreement in place. This was a signed document between the resident and an external housing association. Any amendments to this document was communicated to the registered provider and not to the individual to whom the agreement was with. Also evidence was not present to show resident was updated with issues pertaining to the agreement either by the housing association

or the provider. This required review to ensure each resident was afforded the right exercise their legal rights.

As part of previous inspection in February 2023 assurances were requested with respect to the integrity of the fire doors. The provider had submitted a compliance plan response to ensure this was addressed by the end of May 2023. At the time of the inspection this action had yet to be completed. While an external agency had completed a review in December 2023, no actions had been taken to ensure the centre was provided with safe and effective containment measures. The registered provider was issued an urgent action to ensure assurances were in place pertaining to the integrity of all fire doors on the day of the inspection.

The provider had completed a review of evacuation drill after the previous inspection to ensure all residents were aware of the correct procedure to follow in the event of an emergency in their immediate building area. This included consultation with an external expert and development of a site specific guidance document should an emergency situation arise.

Regulation 13: General welfare and development

All residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. The residents' choice of activities was respected.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured the designated centre was kept in a good of state of repair internally. While the areas of the centre visited presented as clean and decorated in line with residents own interests and tastes, actions from the previous HIQA inspection had not been completed in accordance with the submitted plan. Areas of maintenance remained outstanding since first identified in February 2023. Residents continued to raise outstanding repairs and maintenance concerns to staff and management. Outstanding works included:

- Storage facilities in bathroom of shared apartments.
  Painting throughout.
  Removal of pipework and services post removal of toilet facilities.

Judgment: Substantially compliant

Regulation 20: Information for residents

A residents guide was prepared by the provider which contained all of the information as required by Regulation 20.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured there were systems in place for the assessment, management and ongoing review of risks in the designated centre. This included guidance on how to implement assessments and escalation procedures.

Risks were managed and reviewed through a centre-specific risk register and individual risk assessments. The risk register outlined the controls in place to mitigate the risks. However, not all risk assessments were risk rated in accordance to the accurate likelihood and impact of the risk. Due to this a number of risks had not been escalated as required. Also, a number of risk assessments reviewed did not incorporate identified aspects of risk.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not ensured that there were adequate measures in place for the containment of fire within the designated centre. There was no evidence presented on the day of the inspection that the registered provider had taken adequate actions to address the risk of fire within the centre regarding building services.

It has been identified at a previous inspection in February 2023, within the provider six monthly unannounced visit to the centre in June 2023 and through the provider quality enhancement plan that there were notable concerns of the integrity of several fire doors within the centre. The provider had stated in their compliance plan response that measures would be taken to ensure compliance with Regulation 28 no later than the 30th of May 2023. However, on the day of the inspection, these actions remained outstanding with no time-bound plan to ensure actions were taken in a timely manner to ensure the safety of residents.

Judgment: Not compliant

Regulation 8: Protection

The provider had systems in place to safeguard residents. There was evidence that incidents were appropriately reviewed, managed and responded to. The residents were observed to appear comfortable in their home. Staff spoken with, were found to be knowledgeable in relation to their responsibilities in ensuring residents were kept safe at all times.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, the registered provider had ensured the centre was operated in a manner which respected the rights of residents. Residents were consulted in their care and support, and were supported to exercise choice in their daily life. However some improvements were required. For example, while resident meetings occurred actions arising from same were not followed through. This is addressed under Regulation 34.

Where the residents had a tenancy agreement in place, information pertaining to this and any amendments to agreement were communicated to the provider and not directly to the resident. There was no evidence to provide assurances that residents were communicated with respect to changes to the signed document or any issues arising with this.

Judgment: Substantially 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	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St. John of God Kerry Services - Supported Living OSV-0002927

Inspection ID: MON-0033082

Date of inspection: 16/01/2024

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	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: • Floor plans will be changed in line with the new function of the room and resubmitted. Timeframe for Completion: 29/02/2024	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Register Provider has enlisted an External Fire Expert to conduct a full survey report on all doors in Supported Living Apartments No 2, 3,15,17,18 Brooklodge and 2,5,7 Riverwell House. The total number of internal doors amounts to 40. INSPECTION: • Each door was checked/observed individually. • A general examination of door leaf, frame and ironmongery was carried out. • Type of ironmongery and fire seals was noted. • Door leaf size and thickness measured. • Gaps to thresholds measured (underside of door leaf to floor finish).	

• Gaps between leaf and door frame in excess of 4mm to sides and head, noted.
• Any apparent defects noted, including to fire seals.
• Alignment of door leaf to frame and stops, noted.
• Closing and latching ability of doors was observed and noted.
• The location of Fire Detection and Alarm Panels was noted, for possible future interface with Free-Swing Closers, or the like.

PHOTO SURVEY:
• A full photographic record of the doors has been carried out.

FIRE DOOR CERTIFICATION:
DOORS & FRAMES:
GAPS
IRONMONGERY / DOOR FURNITURE
SIGNAGE:

Survey was completed on the 19/12/2023.

External Fire Expert will be engaged to cost and complete a full scope of works based on their survey report.

Timeframe for completion and submission of costings: 19/01/2024 (Completed)

The Registered Provider has engaged with the Housing Associations Building Contractor to complete identified works which will bring the Register Provider into compliance with Regulation 28(2)(a) and 28(3)(a).

Identified works will be completed by: 30/09/2024.

The Registered Provider and the Organisations National Health and Safety Coordinator have now conducted two fire risk assessments.

Risk Assessment 1 Scope:
The risk of harm to a resident in their own supported single living arrangement due to the risk of fire and associated spread of smoke/fire within the single living arrangement if a fire was to occur.

Risk Rating Likelihood X Impact
Unlikely X Extreme
2 X 5 = Orange 10

Risk Assessment 2 Scope:
The risk of harm to a staff in their own supported single living arrangement due to the risk of fire and associated spread of smoke/fire within the single living arrangement if a

fire was to occur.

Risk Rating Likelihood X Impact
Unlikely X Extreme
2 X 5 = Orange 10

Action Plan

• The Registered Provider will arrange for Fire Awareness Training for residents. Completed by 28/02/2024.

• The Register provider will conduct an internal Fire Safety Audit within the designated centre. Completed by 24/01/2024. (Completed)

• All fire doors identified by External Fire Expert that require works carried out to meet required standards will be completed by 31/05/2024.

• All fire doors identified by External Fire Expert as requiring replacement to be replaced with new certified fire door sets will be completed by 30/09/2024.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• Residents meeting minutes template reviewed and distributed via email to staff team.
Timeframe for Completion 15.02.2024 (Completed)

• Residents meeting minutes template will be discussed with staff team in next team meeting.
Timeframe for Completion 29.02.2024.

• PIC discussed complaints process with staff team and highlighted the importance of utilizing the complaints process.
Timeframe for Completion 29.02.2024

• PIC highlighted to staff team that if residents do not wish to make a formal complaint, staff can do so on their behalf.
Timeframe for Completion 15.02.2024 (Completed)

• PIC emailed all staff members a copy of the complaints policy and asked all staff to familiarize themselves with same.
Timeframe for Completion 15.02.2024 (Completed)

• Complaints policy will be discussed in February team meeting.
Timeframe for Completion 29.02.2024.

• Review of resident meeting minutes will now be a standing agenda item at staff team meetings.
Timeframe for Completion 29.02.2024.

• Review of resident meeting minutes will now be a standing agenda item at staff team meetings.
Timeframe for Completion 29.02.2024.

• ADM coordinator will complete complaints training with all residents in the designed Centre.
Timeframe for Completion 28.03.2024

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• PIC followed up with procured supplier following inspection and storage facilities will be delivered by 16.02.2024.

Timeframe for completion: 16.02.2024 (Completed)

• Report to be compiled by PIC highlighting areas as a priority for painting. Same will be sent to the housing association for review and a schedule of paint works will be identified.

Timeframe for completion: 31.12.2024

• Removal of pipework and services post removal of toilet facilities will be reviewed by Maintenance to identifiy necessary works to be completed. Works will be completed by 30.04.2024.
Timeframe for completion: 30.04.2024

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Registered Provider and the Organisations National Health and Safety Coordinator have now conducted two fire risk assessments.

Risk Assessment 1 Scope:

The risk of harm to a resident in their own supported single living arrangement due to the risk of fire and associated spread of smoke/fire within the single living arrangement if a fire was to occur.

Risk Rating Likelihood X Impact
Unlikely X Extreme
2 X 5 = Orange 10

Risk Assessment 2 Scope:

The risk of harm to a staff in their own supported single living arrangement due to the risk of fire and associated spread of smoke/fire within the single living arrangement if a fire was to occur.

Risk Rating Likelihood X Impact
Unlikely X Extreme
2 X 5 = Orange 10

• These risk assessments will remain under ongoing review quarterly at risk forum or as the need arises.

Completed on: 19/01/2024 (Completed)

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Register Provider has enlisted an External Fire Expert to conduct a full survey report on all doors in Supported Living Apartments No 2, 3,15,17,18 Brooklodge and 2,5,7 Riverwell House.

The total number of internal doors amounts to 40.

INSPECTION:
• Each door was checked/observed individually.
• A general examination of door leaf, frame and ironmongery was carried out.
• Type of ironmongery and fire seals was noted.
• Door leaf size and thickness measured.

• Gaps to thresholds measured (underside of door leaf to floor finish).
• Gaps between leaf and door frame in excess of 4mm to sides and head, noted.
• Any apparent defects noted, including to fire seals.
• Alignment of door leaf to frame and stops, noted.
• Closing and latching ability of doors was observed and noted.
• The location of Fire Detection and Alarm Panels was noted, for possible future interface with Free-Swing Closers, or the like.

PHOTO SURVEY:
• A full photographic record of the doors has been carried out.

FIRE DOOR CERTIFICATION:
DOORS & FRAMES:
GAPS
IRONMONGERY / DOOR FURNITURE
SIGNAGE:

Survey was completed on the 19/12/2023.

External Fire Expert will be engaged to cost and complete a full scope of works based on their survey report.

Timeframe for completion and submission of costings: 19/01/2024 (Completed)

The Registered Provider has engaged with the Housing Associations Building Contractor to complete identified works which will bring the Register Provider into compliance with Regulation 28(2)(a) and 28(3)(a).

Identified works will be completed by: 30/09/2024.

The Registered Provider and the Organisations National Health and Safety Coordinator have now conducted two fire risk assessments.

Risk Assessment 1 Scope:
The risk of harm to a resident in their own supported single living arrangement due to the risk of fire and associated spread of smoke/fire within the single living arrangement if a fire was to occur.

Risk Rating Likelihood X Impact
Unlikely X Extreme
2 X 5 = Orange 10

Risk Assessment 2 Scope:
The risk of harm to a staff in their own supported single living arrangement due to the

risk of fire and associated spread of smoke/fire within the single living arrangement if a fire was to occur.

Risk Rating Likelihood X Impact
Unlikely X Extreme
2 X 5 = Orange 10

Action Plan

• The Registered Provider will arrange for Fire Awareness Training for residents. Completed by 28/02/2024.

• The Register provider will conduct an internal Fire Safety Audit within the designated centre. Completed by 24/01/2024. (Completed)

• All fire doors identified by External Fire Expert that require works carried out to meet required standards will be completed by 31/05/2024.

• All fire doors identified by External Fire Expert as requiring replacement to be replaced with new certified fire door sets will be completed by 30/09/2024.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Residents meeting minutes template reviewed and distributed via email to staff team.
Timeframe for Completion 15.02.2024 (Completed)

• Residents meeting minutes template will be discussed with staff team in next team meeting.
Timeframe for Completion 29.02.2024.

• PIC discussed complaints process with staff team and highlighted the importance of utilizing the complaints process.
Timeframe for Completion 29.02.2024

• PIC highlighted to staff team that if residents do not wish to make a formal complaint, staff can do so on their behalf.
Timeframe for Completion 15.02.2024 (Completed)

• PIC emailed all staff members a copy of the complaints policy and asked all staff to familiarize themselves with same.
Timeframe for Completion 15.02.2024 (Completed)

• Complaints policy will be discussed in February team meeting.
Timeframe for Completion 29.02.2024.

• Review of resident meeting minutes will now be a standing agenda item at staff team meetings.
Timeframe for Completion 29.02.2024.

• ADM coordinator will complete complaints training with all residents in the designed Centre.
Timeframe for Completion: 28.03.2024

• Residents Service agreements reviewed, and maintenance responsibility list attached to the service agreement and distributed to all residents.
Timeframe for Completion: 29.02.2024 (Completed)

• Maintenance responsibility list discussed in residents March monthly meeting.

Timeframe for completion: 28.03.2024

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(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	29/02/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2024
Regulation	The registered	Not Compliant		30/09/2024

23(1)(c)	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.		Orange	
Regulation 23(2)(a)	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 prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	30/09/2024
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	Not Compliant	Orange	19/01/2024

	system for responding to emergencies.			
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	30/09/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/09/2024
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	28/03/2024
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	28/03/2024
Regulation 09(2)(b)	The registered provider shall	Substantially Compliant	Yellow	28/03/2024

	ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Substantially Compliant	Yellow	28/03/2024