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 Kildare Services - DC7
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	27 January 2022
Centre ID:	OSV-0002944
Fieldwork ID:	MON-0029060

About the designated centre

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

DC 7, operated by St. John of God Community Services, is registered for 25 residents. Twenty-one of whom, both male and female, live across five terraced homes and one apartment backing onto a campus setting located in a large town in Co. Kildare. Within the main buildings, each resident has their own bedroom and share common areas with other residents. Residents with an intellectual disability and mental health issues are supported by social care workers, nursing staff and a healthcare assistant. Some residents attend various day programmes provided by St. John of God Kildare services, and some residents are supported to participate in activities in their local community or stay at home on days that they choose. Residents have access through a referral system to the following multi-disciplinary supports psychology, psychiatry and social work. All other clinical support is accessed through community-based primary care with a referral from the individuals GP as the need arises.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	21

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
Thursday 27 January 2022	09:30hrs to 17:00hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The designated centre registered for 21 residents consists of six properties; five adjoining terrace houses and a separate apartment, all backing onto the provider's campus setting. Upon the inspector's arrival to the first house, three residents were getting ready for the morning. One resident was preparing their breakfast and told the inspector that they were due to leave for their day service. The resident spoke about how happy they were returning to their day services after being off during the pandemic. A second resident spoke to the inspector about their family members and how they enjoyed visiting and speaking on the phone with them.

The residents in this centre used verbal and non-verbal forms of communication, so where appropriate, their views were relayed through staff and management advocating on their behalf. Residents' views were also taken from the centre's annual report; the feedback in the report was positive and comments relayed that residents were happy in living in their home, that they felt safe and praised staff for their support during the pandemic.

The inspector sat with the residents for a period of time and observed that the residents appeared comfortable in the presence of staff. A staff member placed a drink within easy reach of the resident, and the inspector observed that the drink was prepared in line with the resident's recommended eating and drinking guidelines.

The staff members present were seen to engage with residents in a pleasant and respectful manner during the inspection. For example, staff were overheard warmly greeting one resident after returning from their day services. Some residents attended day services away from the designated centre, while others received their day services in the centre. Some residents choose not to return to day services after they had reopened and this choice was respected. The inspector met with one resident who had decided not to return to their day service placement as they preferred the slower pace to their day. The provider had increased staffing supports in place in response to those residents choosing to avail of activities from their homes. Another resident was observed leaving the designated centre with their one-to-one staff support to take a train trip to Bray.

Systems were in place for individual residents to be given information and consulted on a one-to-one basis also. This was done through a key working system where each resident had a specific member of staff assigned to them as a key worker. This key worker then meets with a particular resident on a regular basis to give them information and consult with them. For example, one resident who had purchased a computer tablet had met with their keyworker to go through skills teaching for taking photos and making video calls to family. The resident also had goals of making coffee for themselves and ordering coffee and cake from a local cafe.

It was evident that staff were working with residents to develop their knowledge and skills regarding self-care and protection through discussions at residents' meetings and meetings with their keyworkers. Staff were meeting with residents to discuss respecting peers and positive peer relationships. Safeguarding was also being discussed regularly by the staff team at handover and staff meetings. The provider was actively reviewing assessments to ensure that each resident in the centre was not adversely affected by changing needs in the centre.

Other records reviewed included notes of residents' meetings called 'Speak up meetings' that took place in the centre on a monthly basis. Such meetings were facilitated by staff and were used to give residents information on issues such as complaints, safeguarding and advocacy and for residents to talk about topics important to them. Human rights, respect of peers and reopening of day services were recent agenda items viewed by the inspector. Information around the complaints procedures was seen to be on display in the designated centre with records maintained of any complaints made. Records of any complaints made were kept which included details of how they were responded to and whether or not the residents or families raising complaints were happy with the outcome. In the complaints documents reviewed, it was indicated that residents and families were happy with such outcomes.

In summary, the inspector found that each resident's well-being and welfare was maintained to a good standard. However, premises refurbishment works were required across the houses to ensure they were maintained to a good standard and could promote optimum infection control standards. Fire containment measures required improvement also.

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

This designated centre was previously inspected in July 2021, when the isolation unit attached to this centre for COVID-19 was inspected. Due to concerns identified by the inspector regarding the suitability of the building to accommodate self-isolating residents, the provider was issued with three immediate actions relating to governance and management, risk management, and infection prevention on the day of inspection. The provider took substantial corrective action to respond to the issues raised. Also, in December 2021, the provider had applied to remove the isolation unit from the centre as it was no longer being utilised for this purpose. In the previous inspection in January 2020, the inspector visited all houses in the designated centre. At the time of that inspection, the centre was subject to a restrictive condition of registration to ensure that the centre's decongregation plan

was implemented, which would afford residents a more comfortable living environment. Due to the successful transition of two residents to their new homes, this restrictive condition was removed in May 2021. The purpose of this inspection was to monitor the provider's ongoing regulatory compliance across all houses in this centre.

Two social care leaders reported to the person in charge and assisted the person in charge in ensuring that the centre was run effectively and that it was properly monitored. The person in charge reported to the area's programme manager. There was evidence of regular meetings between the programme manager, the person in charge, and the two team leaders demonstrating that the service was being evaluated on a regular basis. Staff and management were clearly advocates for residents' rights and ensuring that a high quality of life was provided in accordance with their wishes. The person in charge informed the inspector of on-coming changes to the designated centre involving a reconfiguration and a review of the persons in charge current large remit. These changes would allow the person in charge greater governance oversight of the centre.

As part of the provider's monitoring systems, the provider had been carrying out annual reviews and six-monthly unannounced visits as required by the regulations. Such visits focused on the quality and safety of the service provided. The last unannounced visit in December 2021 was completed remotely due to a COVID-19 outbreak at the time of the visit. While the audit tool was comprehensive in nature and captured many areas of service provision such as staffing, incident management and safeguarding, the inspector found that due to the audit being completed remotely, it had missed out on areas relating to infection prevention and control measures outlined in the next section of the report.

Under the regulations, the provider must ensure that there are suitable staffing numbers and skill mix in place to support residents.
Based on the overall findings of this inspection, the inspector was satisfied that the provider was discharging these requirements. It was noted though although the centre was operating slightly below its stated whole time equivalence (WTE) as laid out in the centre's statement of purpose, vacancies were actively being recruited. On review of the rosters, the inspector found that regular relief staff were covering shifts as required, providing continuity of staff ensuring familiarity with residents and the operations of the centre. The provider also was committed to ensuring residents were supported to remain in their homes if they did not want to attend day services.

Staff were provided with training and refresher training in line with residents' assessed needs. In addition, the provider had identified that additional staff training was required in line with residents' changing needs, such as dementia training. A review of training records found that all staff had completed the training outlined as required by the registered provider. There were appropriate arrangements in place for the supervision of the staff team, and regular one-to-one supervision meetings were taking place with all staff members.

The inspector reviewed the statement of purpose and floor plans of the centre. As part of the provider's application to remove the restrictive condition of registration,

an updated version of the centre's statement of purpose was provided, an important governance document that forms the basis of a condition of a designated centre's registration. The statement of purpose showed recent vacant bedrooms had been reassigned as additional sitting rooms to enhance the limited communal living areas. However, on the walk-around of the houses, the inspector found that the four newly appointed sitting rooms were not fit for purpose or being used as stated. For example, these rooms had become storage areas for files, Christmas decorations, and unused equipment due to limited storage within the designated centre.

Regulation 14: Persons in charge

The person in charge worked full time, they had a remit over this designated centre and another centre. The person in charge was found to be suitably skilled, qualified and experienced to fulfil the role. They were supported in their role by a staff team that was comprised of two social care leaders and social care workers and ensured they had regular contact with all staff members. They were very knowledgeable of the requirements of their role and responsibilities.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangements in place were found to be adequately supporting residents' assessed needs during this inspection. Staffing arrangements were found to be flexible regarding residents' changing needs and provided for continuity of care. Where there were any gaps in staffing levels due to leave; these were covered by regular relief staff. During this inspection it was seen that the current staffing levels were slightly below what the statement of purpose provided for but it was acknowledged that the provider was making active efforts to address this. It was also seen that throughout this inspection, staff members present engaged appropriately and respectfully with residents. From the staff rosters that were being maintained in the centre, it was noted that there was a core staff team in place to support residents which promoted a consistency of care and familiarity with the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were provided with training and refresher training in line with residents' assessed needs. In addition, the provider had identified that additional staff training was required in line with residents' changing needs. Staff also had completed recent baseline and refresher training in infection control prevention and management. This included hand hygiene, the correct use of personal protective equipment and breaking the chain of infection

There were appropriate arrangements in place for the supervision of the staff team, and regular one-to-one supervision meetings were taking place with all staff members. The person in charge and social care leader shared supervision responsibilities for the staff team, including relief staff.

Judgment: Compliant

Regulation 23: Governance and management

The centre had a clearly defined management structure in place, consisting of an experienced person in charge who worked on a full-time basis in the organisation and was supported by two social care workers. The centre was also monitored and audited as required by the regulations. There was an annual review of the quality and safety of care available in the centre for 2020, along with six-monthly auditing reports/unannounced visits. The annual review included feedback from residents and addressed the quality and safety of care and support in accordance with relevant national standards.

Staff had access to the support of the management team should they have any concerns relating to residents care and support in the centre and members of the management team met with were committed to ensuring a quality and safe service was delivered to residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose must contain specific information such as details of the services and facilities to be provided by the registered provider to meet residents' care and support needs. The description of the rooms in the designated centre including their primary function were not in keeping with the statement of purpose at the time of this inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

Information on the complaints procedure was on display in the designated centre. Residents were supported to raise complaints and records of any complaints made were maintained.

Judgment: Compliant

Quality and safety

On the whole, the inspector found that processes were in place to ensure that residents were safe and receiving high-quality care and support. Discussions with residents and staff, as well as a review of documents, revealed that staff and the local management team were working hard to ensure that residents lived in a warm and caring environment where they were supported to have control over and make decisions in their day-to-day lives. However, some improvements were required under the quality and safety regulations, namely fire safety, infection prevention and control measures and premises.

There were policies and procedures relating to safeguarding and protection in the centre. Allegations and suspicions of abuse were reported and followed up in line with organisational and national policy. The inspector found that there had been a satisfactory level of scrutiny by the registered provider of all alleged incidents to guarantee that safeguarding arrangements in place ensured all residents' safety and welfare. The inspector reviewed a sample of documentation relating to alleged safeguarding incidents that had taken place over the last twelve months. The inspector found that although there had been an increase in incidents, these had been reviewed in an effective manner. For example, the provider had implemented a number of additional control measures to support residents overseen by the multi-disciplinary team. The person in charge spoke to the inspector that due to changing needs, a transition was planned to take place the following week to better meet residents' needs.

The inspector completed a walk-through of the five houses and separate apartments with the person in charge and social care leader. Each resident had their own bedroom. The person in charge had self-identified a number of premises issues prior to the inspection that required attention, but due to delays in these works being approved, these remained awaiting completion. On the walk around, the inspector also identified additional premises and infection prevention and control risks that could compromise effective cleaning and decontamination practices. These are explained in further detail under regulations 17 and 27 below.

All houses were fitted with fire safety systems, including fire alarms, emergency lighting and fire extinguishers. The cognitive understanding of residents was adequately accounted for in the evacuation procedures and in the residents' individual personal evacuation plans. All staff had received suitable training in fire prevention and emergency procedures, building layout and escape routes, and arrangements were in place for ensuring residents were aware of the procedure to follow. However, there were inadequate fire containment measures throughout the centre. These are important in preventing the spread of fire and smoke while also providing a protected evacuation route. The provider was aware of this requirement, and the inspector was informed of the plan to fit fire door closures within the centre. The person in charge had also reviewed the published fire guidance for further fire improvements that could be made and had purchased a new fire-retardant shelter for those residents that smoked.

As required by the regulations, each resident had their own individual person plan, which are intended to set out the needs of residents and provide guidance for staff in supporting these needs. The inspector reviewed a sample of residents' personal plans and found that they had been informed by relevant assessments and generally contained a good level of guidance on how assessed needs were to be met. For example, personal plans were seen to include information on how to support residents with skills teaching. A process was in operation for residents to be involved in the reviews of their personal plans through a process of person-centred planning with their keyworkers and family members. From speaking to local management, it was evident they had good systems in place to review personal plans and address any gaps or inconsistencies in quality.

Appropriate healthcare was made available to residents having regard to their personal plans. Plans were regularly reviewed in line with the residents' assessed needs and required supports. They had assessments in place, and specific health management plans and health monitoring plans were developed and reviewed as required. For example, hypertension care plans were individualised to the resident's specific requirements. Each resident also had a hospital passport which contained important information for them to bring with them, should they require admission to the hospital.

Where required, therapeutic interventions were implemented with the informed consent of each resident and were reviewed as part of the personal planning process. Where a resident's behaviour necessitated intervention, every effort was made to identify the cause of the behaviour, and applicable strategies were put in place to support the resident. The inspector found there was a strong recognition of

the appropriate usage of restrictive practices and ensuring they were applied according to national policy and evidence-based practice.

Regulation 17: Premises

Some premises improvements were required to ensure the centre was maintained in its most optimum condition. The inspector was informed that the provider had approved a number of significant refurbishments, and these included bathrooms, kitchens and replacing boilers. On the walk-around the inspector observed:

- A number of areas required painting.
- A damaged wall needed replastering.
- The inspector observed there was a lack of storage options within the houses. For example, a bicycle kept outside had rusted due to unsuitable outdoor storage, and some communal rooms had been used as storage areas.
- A light fixture needed replacing.
- Powerwashing of outside paths was required to remove moss and debris.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and staff safety may have been compromised. The approach to risk management was dynamic, individualised and supported responsible risk-taking as a means of enhancing quality of life while keeping residents safe from harm. The provider had ensured that all risk management plans had been regularly reviewed. The provider ensured that there was a system in place in the centre for responding to emergencies and there were arrangements in place for the investigation of and learning from adverse events.

Judgment: Compliant

Regulation 27: Protection against infection

There were improvements required in relation to the premises that impacted the overall infection control measures and standards in the centre and across all the houses that made up the centre. The inspector also observed practices that were not consistent with the national standards for infection prevention and control in community services. During the feedback session, a detailed discussion took place

regarding the findings and the roll-out of the provider's infection prevention and control committee actions and recommendations.

- A clinical bin in a bathroom was rusted and therefore could not be effectively cleaned or decontaminated.
- A clinical bin outside was found not to be locked. The protocols for locking and opening the bin required review to ensure ease of access to staff needed to use the clinical bin.
- A sink not in use in the centre did not form part of any water management system or Legionella check.
- Two cigarette bins were overflowing with cigarettes.
- Some beds required replacing that could not be effectively cleaned.
- Mops were observed stored outside and did not adhere to provider policy.
- An identified IPC risk for one house required review to ensure this risk could be appropriately responded to in a timely manner.
- A chair kept in one bathroom was visibly unclean and did not appear on any cleaning checklists

Judgment: Not compliant

Regulation 28: Fire precautions

Fire safety systems where in place in the designated centre including a fire alarm system, emergency lighting and fire extinguishers. Such equipment was being serviced by external contractors at the required timeframes. Internal staff checks were also being carried out. While the provider had installed fire doors throughout all houses, not all doors had been fitted with door closing devices. This required improvement to ensure the most optimum fire containment measures were in place. Also, it was observed during inspection that one fire door was wedged open with a door stopper.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that all residents had an assessment of need and a personal plan in place that was subject to regular review. Assessments of need clearly identified levels of support required. Residents had social goals in place that were realistic and individualised. Goals in place had action plans to support residents to achieve them. Each resident had an annual personal planning meeting with their keyworker, family and other members from the mutli-disciplinary team where their plan of care and goals were reviewed and updated.

Judgment: Compliant

Regulation 6: Health care

From reviewing a sample of residents' health management plans and recent consultations with allied health professionals, it was evident that residents' changing needs were being closely monitored and supported. Further consultations with the relevant allied health professionals were being arranged promptly. Staff who spoke with the inspector were knowledgeable in relation to residents' healthcare needs which included dementia, diabetes and dyshagia. Residents were supported to attend National Screening programmes and yearly Flu vaccinations. Appointments with allied health professionals were logged, and the advice and guidance from these professionals were then updated into residents' personal plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

Positive behavioural support plans were in place for residents were appropriate and were guiding staff practice. The service provided access to allied healthcare professionals, including psychology and psychiatry. In addition, support plans were subject to review on a regular basis with the relevant healthcare professionals. Restrictive practices were used in accordance with national policy and evidence-based practice and were subject to regular review. Alternative therapeutic measures were considered and utilised before the use of a restrictive practice. All staff had up to date training for the safeguarding and protection of vulnerable adults and the management of actual and potential aggression (MAPA).

Judgment: Compliant

Regulation 8: Protection

There were effective systems in place regarding all current safeguarding concerns in the centre. All staff had received training in safeguarding and the services of a designated safeguarding officer were available to support residents and staff.

The inspector observed that there were some safeguarding issues currently open in the centre and these were mainly related to adverse peer-to-peer verbal interactions. However, all adverse incidents were being recorded, reported and responded to by the person in charge.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not 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

Compliance Plan for St. John of God Kildare Services - DC7 OSV-0002944

Inspection ID: MON-0029060

Date of inspection: 27/01/2022

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 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: 1. As per Statement of Purpose rooms identified as sitting rooms have now been cleared of items stored. Going forward rooms will not be used for storage and used in line with Statement of Purpose. Completed.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. Painting schedule will be agreed and painting & repairs to walls completed by the Housing Provider by 27th October 2022. 2. Storage options for item identified outside has been resolved with resident as of 1st of April 22. Completed. 3. All items identified in communal sitting rooms have being removed as of 1st April 22. Completed. 4. Light fixture identified was replaced on 28th January 22. 5. Power washing identified for completion as part of Landscaping maintenance contract. For completion by end of May 2022.	

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. Clinical waste bin identified replaced 28th January 2022. Completed.
2. Protocol / procedure for managing clinical waste will be reviewed to address issues highlighted by end of April 2022.
3. A Sink identified as not in use, has been disabled and taps removed as of 25th March 2022. Sink will be removed as part of scheduled maintenance with the Housing Provider by 27th October 2022.
4. Cigarette bins on walls have been removed as of 1st of April 2022. Appropriate disposal bins of cigarettes have been put in place at smoking shelter for residents. Daily check on cigarette bins included in daily duties/routine as of 1st of April 2022.
5. Beds identified as requiring replacement have been replaced as of 15th February 2022.
6. As per policy storage of mops/buckets reiterated with all staff in DC7. This procedure will be discussed and refreshed at all staff meetings in DC7 by the end of April 2022.
7. IPC risk has been addressed through IPC Hazard Identification and controls for DC7. Completed 16th March 2022.
8. Chair identified in one bathroom, has been removed. Completed 28th January 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A schedule has been agreed with the Housing Provider to fit all door closing devices outstanding by the 27th October 2022.
2. Automatic magnetic door holder linked to fire alarm has been fitted to door identified as wedged open. Completed 25th March 2022.

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 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	27/10/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/04/2022

Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	27/10/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	15/02/2022