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:	Community Living Area 5
Name of provider:	Muiríosa Foundation
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	03 November 2021
Centre ID:	OSV-0004079
Fieldwork ID:	MON-0026419

About the designated centre

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

This designated centre comprises of two houses next to each other on a campus based setting in a small town in Co. Kildare. The designated centre provides support to three residents with varying needs pertaining to intellectual disability, hearing impairment and autism. One of the houses is a bungalow with four bedrooms, one of which is being used as a staff office and staff overnight room. There is a sitting room, a kitchen-dining room and a small outdoor area to the back and a garden and patio area to the front. The other house is also a bungalow with four bedrooms one of which is used as a staff office and staff overnight room. There is one en-suite and one bathroom. There is a kitchen-dining room and a sitting room. There is a large garden to the rear and side of the house with an outdoor patio and seating area. There are cars available for the use of residents in both houses. The person in charge works full-time at this designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 November 2021	10:30 am to 5:30 pm	Sarah Cronin	Lead

What residents told us and what inspectors observed

This inspection took place during the COVID-19 pandemic and the inspector followed public health guidelines throughout the inspection. The centre comprises two bungalows on a campus setting near a town. One house provides an individualised, bespoke service for a person with autism while the other provides a service to two residents with sensory and physical disabilities. The inspector met and spent time with each resident over the course of the day, reviewed documentation, observed interactions and spoke with staff members to inform the judgements in this report. Findings were largely positive, with some improvements required in the areas of staff training and fire precautions.

The inspector found that the centre provided an excellent standard of person-centred care to residents. Residents were engaged in a number of local organisations such as the tidy towns committee and in activities to support charities of their choice. All of the residents had contributed to a COVID-19 time capsule for the local town and two of the residents had recently taken part in an intergenerational project with a secondary school. It was notable in this centre the level of commitment displayed by staff in ensuring residents remained connected to their families and to the local community throughout the restrictions. Residents interests were not only provided for in-house but staff had actively sought ways for these activities to be progressed and further developed in challenging circumstances caused by the COVID-19 restrictions. One example of this was a resident who enjoyed going clothes shopping. When restrictions came into force, a staff member cultivated a relationship with a local boutique and was able to take clothes out to the resident in the car. Another example was where a staff member had sourced a space for a resident to use as an art studio to ensure they continued to enjoy art while lessons were suspended. Residents had also been supported to take part in some activities online.

The inspector received four questionnaires which had been circulated to the person in charge prior to the inspection. The questionnaires seek resident feedback on a number of areas including general satisfaction with the service being delivered, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, rights, activities, staff supports and complaints. Residents reported that they liked living in their home and they enjoyed the wide array of activities and projects they were involved in. A family member was highly complimentary of the service, particularly of the staff, describing them as " exceptional".

The inspector met and spent time with all of the residents during the day. Two of the residents communicated using speech while the third resident used Lámh and natural gesture. The first resident lived alone and had the support of a core and stable staff team. The resident's home had been altered to make use of all available space to support the resident engage in different activities during the COVID-19 pandemic. Staff had set up a beauty room with a dressing table and nice furniture for the resident to do their make up and get their hair done. Another room had been

set up as a craft room. There was photographs of the resident and their family throughout the house. On speaking with the resident and the staff, it was evident that they were receiving very high quality care which was attuned to their specific needs. Staff had significant experience in ensuring attention to detail in supporting the resident in order to ensure that they remained secure and happy in their home. The resident and the staff told the inspector that they were on a tenancy association and had a meeting later that day. They had their bags packed for an upcoming hotel break which they were looking forward to. The resident was supported to cook dinner and bake and deliver this to their family who lived nearby. This resident was also involved in interviewing their support staff to ensure that staff members were the right match for them.

The inspector met the second resident and engaged with them using Lámh. They told the inspector that they were excited about Christmas. This resident had recently taken part in a biodiversity programme and re-housed a hedgehog as part of a project. They had carried out a traffic light survey in the town and submitted this to the Local Councillor. Staff told the inspector that the resident had a stand in the local supermarket to encourage people to take some tomato plans and grow them. They had two photographs in the current Tidy Towns calendar which they were reported to be very proud of.

The inspector met the third resident outside of the house in the morning. They went to the Kildare Stud with a staff member and had their lunch. The inspector spoke with them on their return. They showed the inspector photographs they had taken on their tablet of their outing and of them doing other activities. The resident was a talented artist and was hoping to do an art class as part of heritage week next summer. The resident told the inspector that they enjoyed having their family to visit in the centre again.

In summary, from what residents told the inspector, from observations and from reviewing documentation, it was evident that residents were in receipt of good quality care and that they were cared for by a committed and professional staff team. The next two sections of this report present the inspection findings in relation to the governance and management of the centre and how governance and management arrangements affected the quality and safety of the service being delivered.

Capacity and capability

The provider had strong management systems, processes and structures in place to ensure effective oversight of the quality and safety of care being provided to residents. There was a clear reporting structure in place, with the person in charge reporting to the Area Director, who in turn reported to the Regional Director. The provider had set up a Crisis Management Team in order to manage the COVID-19 pandemic. There were emergency on-call arrangements in place and a roster was

sent to staff every two weeks.

Provider level oversight of this centre was achieved through six monthly and annual reviews, as required by the regulations. The annual review included consultation with residents and family members which reported satisfaction with the service. The provider had a number of committees in place to oversee different aspects of residents' care such as the positive behaviour support committee and the restrictive practice committee. There were had a suite of policies in place which are required under Schedule 5 of the regulations. These were regularly reviewed in line with best practice and signed off by staff to indicate they had read and understood these policies. Oversight of the service at centre level was achieved by the person in charge through the use of audits in areas such as medication, health and safety, risk and care plans. The person in charge reviewed each residents daily notes and signed off on these which ensured they remained up to date with any changes in residents' presentation.

The provider had appointed a suitably qualified and experienced person in charge. The person in charge was found to be very knowledgeable about each of the residents' specific needs. The person in charge attended monthly management meetings which included other persons in charge sharing information and learning across centres. The centre was resourced with an adequate number of staff who had the appropriate skills to support residents have a good quality of life and to ensure that their health and social care needs were met. The person in charge had improved systems in the induction of new staff since the last inspection which now included information and protocols pertaining to COVID-19 and emergency procedures. There were adequate arrangements in place for the supervision and performance management of staff. In addition to supervision sessions, the person in charge carried out an observational assessment of staff carrying out personal care with residents on an annual basis to ensure it was of a high standard. There were clear shift planners in place with identified shift leaders. The person in charge were supporting staff development by mentoring staff who wished to progress in areas such as HIQA, the risk register , positive behaviour support and staff training. Staff meetings took place once a month and had a structured agenda. Staff reported being very well supported and encouraged in their roles.

Staff training had improved since the last inspection and the provider had implemented staff training in supporting a person with autism and in Lámh. The inspector noted a sign up in one of the houses to tell visitors that it was a Lámh environment. They had set up a core vocabulary of ten signs which all staff knew and showed to others to ensure that resident was appropriately supported. However, training continued to require some improvement. All staff had completed training in mandatory areas such as manual handling, safeguarding, fire safety and a range of course relating to infection prevention and control such as donning and doffing of PPE, hand hygiene and breaking the chain of infection. Documentation in relation to which courses were required for each house had been done but required attention to ensure they were consistent for each staff member. Some required training were out of date with one staff member requiring refresher training in supporting a person with epilepsy and in the use of buccal midazolam since 2017.

Another staff required training in managing oxygen.

In summary, the provider and the person in charge had the capacity and capability to oversee, monitor and deliver a safe, high quality service to residents. This was evidenced by high levels of compliance on this inspection.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted all of the information required to apply for renewal of registration in line with the regulations and within the required time lines.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge worked full time and had the appropriate qualifications, skills and experience to oversee the service and meet its stated aim and objectives. The person in charge demonstrated that they were highly competent in their role and they were very familiar with each resident and their needs.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that there were adequate numbers of staff with appropriate skills to meet the assessed needs of residents. The provider had increased the number of staff in one of the houses to ensure residents could do activities of their choice on an individual basis if they so wished. Planned and actual rosters were well maintained and showed that there was a stable staff team, with some relief staff doing extra shifts which had been recently allocated to enable residents do activities of their choosing with individualised support.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had completed training in mandatory areas such as manual handling, safeguarding, fire safety and a range of course relating to infection prevention and

control such as donning and doffing of PPE, hand hygiene and breaking the chain of infection. Documentation in relation to which courses were required for each house had been done but required attention to ensure they were consistent for each staff member. However, one staff member had required refresher training in supporting a person with epilepsy and in the use of buccal midazolam since 2017. Another staff required training in managing oxygen. A third staff required training in CPR and supporting people with behaviours of concern. Staff supervision was in place and this included a practical component every year to ensure that care practices remained of a high standard.

Judgment: Substantially compliant

Regulation 22: Insurance

The provider had appropriate insurance in place against risks in the centre as required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider had strong management structures, systems and processes in place to ensure oversight over the safety and quality of care provided to residents. They carried out annual reviews and six monthly audits of the service, as required by the regulations. The annual review included the voices of residents and families which were complimentary of the service. The provider also had a number of committees in place to oversee different aspects of residents' care such as the positive behaviour support committee, health and safety and restrictive practice.

The centre was resourced with the appropriate number of staff who had the required skills to meet residents' assessed needs. Supervision and performance arrangements were in place. The person in charge had oversight of the centre through reviewing daily notes and carrying out a number of scheduled audits in areas such as medication management, finances, health and safety and care plans. Staff meetings took place monthly and were structured. The person in charge attended monthly management meetings.

Judgment: Compliant

Regulation 3: Statement of purpose

The Statement of Purpose provided to the inspector contained all information required in Schedule 1 of the regulations, it was regularly reviewed and it adequately reflected the service being provided.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of the incident and accident log indicated that all notifiable incidents were notified to the Office of the Chief Inspector within required time frames.

Judgment: Compliant

Regulation 4: Written policies and procedures

The provider had ensured that all policies required under Schedule 5 of the regulations were present, in date and in line with best practice. They were reviewed within required time frames. Staff were required to sign off on policies to indicate that they had read and understood them.

Judgment: Compliant

Quality and safety

The inspector found residents to be receiving good quality person- centred care in this centre. Each resident had an annual assessment of need carried out and this informed their person centred support plan. Residents' person -centred support plans were clearly documented and reviewed each quarter.

Residents were supported to have best possible health. For one resident with autism, staff described how they had worked with a local hospital in order to ensure that any hospital appointments or tests were managed to minimise the resident's stress. For example, allowing staff to play Daniel O'Donnell while a test was going on or minimising wait times for the resident. Residents had availed of National Screening programmes such as BreastCheck and where there was a delay in receiving an appointment, there was evidence of staff following up on this to ensure the residents were seen as quickly as possible. Residents had access to a range of health and social care professionals such as speech and language therapy, occupational therapy, dietetics, physiotherapy , psychology and consultants. An

annual assessment of need was carried out and there were corresponding care plans developed. Records were kept of all appointments and daily observations for residents. Where a health and social care professional had made recommendations, these were clearly documented and integrated into care plans. The Positive Behaviour Support Team met with staff each month to ensure that residents continued to be supported appropriately in relation to behavioural needs. Where any restrictions were in place for residents, they were regularly reviewed. In one case, the need for PRN medication had been eliminated, resulting in a positive outcome for that resident.

The organisation had a number of policies in place to protect residents from abuse and neglect. These included trust in care, protection of vulnerable adults, listening and responding to behaviours of concern, guidance on restrictive practice and rights restrictions and protecting individuals personal possessions. Each resident had an inventory of their personal belongings. Finances were audited regularly. A sample of intimate care plans were viewed by the inspector. These plans were drawn up in line with residents' person -centred support plans and respected each residents' dignity and bodily integrity. An additional measure was in place in the centre, whereby the person in charge did an observation of each staff member performing personal care on an annual basis to ensure best practice. Throughout the inspection, residents were observed to be treated with kindness and their privacy was respected and protected. Staff were knowledgeable about different types of abuse and how to report any concerns they may have.

Both of the houses were warm and homely and decorated in line with each residents' life history and preferences. The first house, as described was designed to best support a resident to engage in different activities in-house which included hair and make-up and crafts. They recently had a fire place put into the sitting room, which they reported to like. There had been a leak in the months prior to the inspection which had required small parts of the floor to be taken up. On the day of inspection, this had been patched up and covered by a rug. The resident in the centre had very specific requirements in relation to people entering their home in addition to health care concerns. Therefore, this work remained outstanding on the day of the inspection. However, there was a very clear record viewed by the inspector of discussions and meetings relating to this issue and how best to get the required works done while minimising distress to the resident. There was a clear plan for this to take place while the resident was on holiday in the coming weeks. The other house was warm and homely and had a resident's art work on the walls. There was ample space in each bedroom for residents to store their personal possessions. This was in a good state of repair internally and externally.

There were good risk management systems in place in the centre. The inspector reviewed the incident and accident log, the safety statement and the risk register. There was clear learning from adverse events documented which were shared with staff at team meetings. Monthly health and safety audits were done and the person in charge then compiled an annual report which was sent to senior management. There were good systems and practices in place to ensure risks were identified, assessed and actions taken to mitigate those risks. The risk register had records of risks at centre and individual levels. They were regularly reviewed. There were a

range of risk assessments done in relation to COVID-19 which were updated to reflect current guidance.

The provider had systems in place to ensure good governance and management throughout the COVID-19 pandemic. The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed and regularly updated. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. On arrival to the centre, the inspector noted appropriate measures in place to manage the risk of COVID-19 for visitors. These included a hand sanitising station, a sign to remind people to sanitise and clean their hands, a temperature check and a declaration to complete. Temperature checks were carried out on staff and residents twice a day. The inspector viewed the cleaning schedule which detailed areas to be cleaned on a daily, weekly and monthly basis. There were a number of standard operating procedures and protocols for staff to follow on cleaning and disinfection, waste management and infection prevention and control. The inspector noted that there were adequate hand hygiene facilities throughout both houses and staff were wearing appropriate levels of personal protective equipment. Both premises were found to be very clean.

Fire safety management systems and structures required improvement. Fire detection systems, emergency lighting and fire fighting equipment were present in both houses, serviced and regularly checked. Drills were carried out regularly and were clearly documented, outlining any required actions to be taken. These demonstrated reasonable evacuation times. There was a schedule in place for drills to ensure that all staff had an opportunity to carry out a drill at least once a year. All residents had a personal emergency evacuation plan in place. One of these plans indicated that wedges were used to enable staff to evacuate a resident in a wheelchair to hold the door open. On one of the drills carried out, staff were unable to find the wedges and this took time to rectify. While the use of wedges had been discontinued on instruction from the Director of Services and this had been communicated to staff, the PEEP had not been updated to reflect these changes. In one house, a ramp was to be fitted to the back door to enable safe egress for a resident who at times required use of a wheelchair. In the other house, all of the doors were open when the inspector walked in. They did not have free swing closers. A fire safety management review which the provider had done in May 2021 indicated that evacuation routes were unsatisfactory and that free swing closers were to be fitted. The door on the hot press in one house also required replacement to ensure it was fire resistant. This was yet to be done.

Regulation 17: Premises

Both of the houses were homely and warm. They were suitably decorated in line with the residents' preferences and needs. In one of the houses, there had been a leak which had required the floor to be taken up. The resident in the centre had

specific requirements in relation to people entering their home in addition to health care concerns. Therefore, this work remained outstanding on the day of the inspection. However, there was a very clear record viewed by the inspector of discussions and meetings relating to this issue. There was a plan in place to do this work while the resident was on holiday to minimise the disruption and stress for the resident. The other house was found to be warm and suitably decorated throughout. Residents' art work was on the walls and it had a homely atmosphere.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had appropriate systems in place to identify, assess and manage risks at centre and individual level. Risk assessments were regularly reviewed and updated as required. Adverse incidents were well documented and learning shared with staff at monthly meetings. Health and safety audits were regularly carried out and an annual report was compiled by the person in charge and sent to senior management. The provider's risk management policy contained all of the information required in the regulations.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had systems in place to ensure good governance and management throughout the COVID-19 pandemic.The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed and regularly updated. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. The provider had recently appointed a 'Covid Lead' within the organisation. They carried out spot checks relating to PPE use and cleanliness regularly. On arrival to the centre, the inspector noted appropriate measures in place to manage the risk of COVID-19 for visitors. Temperature checks were carried out on staff and residents twice a day. The inspector noted that there were adequate hand hygiene facilities throughout both houses and staff were wearing appropriate levels of personal protective equipment. Both premises were found to be very clean.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety management systems and structures required improvement. Fire detection systems, emergency lighting and fire fighting equipment were present in both houses, serviced and regularly checked. Drills were carried out regularly and were clearly documented, outlining any required actions to be taken. These demonstrated reasonable evacuation times. There was a schedule in place for drills to ensure that all staff had an opportunity to carry out a drill at least once a year. All residents had a personal emergency evacuation plan (PEEP) in place. One of these plans indicated that wedges were used to enable staff to evacuate a resident in a wheelchair to hold the door open. On one of the drills carried out, staff were unable to find the wedges and this took time to rectify. While the use of wedges had been discontinued on instruction from the Director of Services and this had been communicated to staff, the PEEP had not been updated to reflect these changes.In one house, a ramp was to be fitted to the back door to enable safe egress for a resident who at times required use of a wheelchair. In one of the houses, all of the doors were open when the inspector walked in. A fire safety management review which the provider had done in May 2021 indicated that evacuation routes were unsatisfactory and that free swing closers were to be fitted. The door on the hot press in one house also required replacement to ensure it was fire resistant.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

All residents had an annual assessment of need carried out and corresponding care plans were developed. Residents also had person- centred plans which were done with residents and reflective of their interests and aspirations. Person centred support plans were reviewed every quarter. A review of the effectiveness of these plans was carried out on an annual basis. It was clear that plans were done with maximum participation of residents.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to have best possible health. Residents had access to a range of health and social care professionals such as speech and language therapy, occupational therapy, dietetics, physiotherapy , psychology and consultants. Records were kept of all referrals, appointments and daily observations for residents. Where a health and social care professional had made recommendations, these were clearly documented and integrated into care plans. The Positive Behaviour Support Team met with staff to ensure that residents continued to be supported appropriately in relation to behavioural needs. Where any restrictions were in place

for residents, they were regularly reviewed. In one case, the need for PRN medication had been eliminated, resulting in a positive outcome for that resident.

Judgment: Compliant

Regulation 8: Protection

The provider had a number of policies in place to guide practice and to ensure that resident were protected from all forms of abuse.The organisation had a number of policies in place to protect residents from abuse and neglect. Each resident had an inventory of their personal belongings. Finances were audited regularly. A sample of intimate care plans were viewed by the inspector. These plans were drawn up in line with each residents' person centred support plans and respected each residents' dignity and bodily integrity. Throughout the inspection, residents were observed to be treated with respect and their privacy was respected and protected. Staff were knowledgeable about different types of abuse and how to report any concerns they may have.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Community Living Area 5 OSV-0004079

Inspection ID: MON-0026419

Date of inspection: 03/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All relevant staff will attend training as scheduled by the Person in Charge: 1. Epilepsy-1 staff booked by 31/01/22 2. Buccal - 1 staff booked by 31/01/22 3. Oxygen- 1 staff booked by 31/01/22 4. CPR- 1 staff booked to complete training by 31/12/21 5. MAPA-3 staff booked to complete refresher training on 13/12/21 and 2 staff booked to complete training by 31/01/22	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The register provider shall provide adequate means of escape, including emergency lighting by: 1. External door and ramp will be fitted to end room exit in one location by 31/03/22. The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires by: 1. PEEP for one resident updated on 05/11/21 by the Person in Charge. 2. Spring release closures to be fitted to 3 doors in one location and all doors in second	

location by 31/03/22
3. . Turn locks fitted on front and back exit doors on 19/11/21 in both locations.
4. Fire door fitted to hot press by 31/03/22.

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	31/01/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/12/2021
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,	Not Compliant	Orange	31/03/2022

	bedding and furnishings.			