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:	Whitmore Lodge
Name of provider:	St John of God Community Services CLG
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	18 January 2023
Centre ID:	OSV-0005811
Fieldwork ID:	MON-0034486

About the designated centre

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

Whitmore Lodge is an eight bedroom unit situated on a campus based setting in Co. Louth. The centre can support eight male and female adults who require nursing support due to changing medical needs. The centre is nurse led 24 hours a day. Health care assistants also play a significant role in supporting residents here. There are six staff allocated to work during the day with residents and three staff at night time. Household staff also work during the day. The person in charge is a qualified nurse and are responsible for two other centres under this provider, a clinic nurse manager is in place to assist with the oversight arrangements in place. Residents are supported to access community facilities in line with their assessed needs. A bus is available to residents. Other activities are available in the centre which includes reflexology and music therapy. This centre has also been approved as a learning environment for student nurses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 18 January 2023	10:15hrs to 19:45hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the governance and management arrangements in this centre were not assuring a safe quality service for the residents. This resulted in a number of regulations requiring significant improvements namely, fire safety, risk management, infection prevention control, general welfare and development and premises. Many of these regulations were found not compliant with the regulations due to the provider not taking timely action to address the issues identified. This was despite a number of those issues been highlighted following the last inspection by the Health Information and Quality Authority (HIQA) and the providers own internal auditing systems.

On arrival to the centre, a staff member went through some precautions around infection prevention and control (IPC) with the inspector. The centre is located on a large campus and comprises of eight bedrooms, a large dining room/sitting room, several storage rooms, a kitchen, offices, a reception area, coffee dock and a conservatory. The inspector observed that the premises were for the most part clean. One resident showed the inspector their bedroom which was in the process of being redecorated. The resident had chosen colours they liked and since the last inspection had gotten a new television for their room.

However; a number of maintenance issues had not been addressed and actions from audits had not been completed. For example; the inspector observed two 'post it' notes on the wall of one resident's bedroom and when they enquired what they were for, staff said they were to indicate where the residents' pictures were to be hung. When the inspector followed up on this, they found that, the resident had been waiting 18 months to have these pictures hung. The inspector also noted that another resident who transitioned to the centre late last year had been waiting almost four months for pictures to be hung in their bedroom.

Hand sanitising gels were located around the premises and staff were observed wearing masks at all times. Increased cleaning schedules were in place and two household staff were employed to keep the cleaning records and activities up to date. Notwithstanding this, the inspector observed a number of maintenance issues that had not been addressed which could pose an infection control risk. For example; there was a gap in one of the windows which could result in rodent infestation. The provider had identified this in an audit 18 months previously and had not addressed the issue. Furthermore, curtains in the dining room had not been cleaned, gaps in the walls of bathrooms had not been filled despite the provider having identified those as posing an infection control risk through their own audits.

The inspector met seven of the residents living in the centre, some of the residents were enjoying a lie on when the inspector arrived and staff were supporting some of the residents with personal care and their meals. The staff were observed to treat the residents with dignity and respect at all times, the inspector observed a staff member promptly responding to a resident who required assistance in a respectful

manner.

On the day of the inspection one resident was attending an appointment and went out for lunch and some shopping afterwards with the staff. The resident appeared very happy on their return to the centre and was showing other staff some of the purchases they had made. However, the inspector observed that many of the other residents had limited activities available to them that day. When the inspector reviewed the residents timetable of activities for the week, there was limited activities available in or outside the centre. For example; one resident had a number of things they liked to do such as; baking, karaoke and dancing, a review of this resident's activity list showed that, none of these activities were planned on their activity timetable.The inspector was informed that activities outside of the centre were sometimes impacted by a shortfall of staff or staff breaks.

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 to each resident living in the centre.

Capacity and capability

This inspection was carried out to follow up on actions from an infection prevention control inspection conducted in this centre in May 2022 where the inspector had identified significant improvements were required. It was also conducted to review the governance and management arrangements in this centre.

Overall, the inspector found that the governance and management arrangements in place in this centre were not adequate and did not provide oversight of the quality and safety of care for residents. As a result a number of regulations inspected against required improvements to include; the person in charge arrangements, governance and management, infection prevention and control, risk management, fire safety and general welfare and development.

Such were the concerns around fire safety, the provider was issued an urgent action plan the day after the inspection and requested to submit assurances to the chief inspector that, the registered provider would take urgent actions to address the concerns identified. These assurances were submitted.

The inspector found that the governance and management arrangements were not effective. While there was a defined management structure in place this was not adequate to oversee the care and support of residents. Actions from audits were not being completed in a timely manner and the management team spoken with were unaware whether some actions had been completed or not.

The arrangements in place to support the person in charge who was responsible for two other designated centres was not sufficient to ensure the service to residents in this centre met their needs.

There was a planned and actual rota in place however, there was a shortfall of staff on the day of the inspection as one staff had taken unplanned leave. This needed to be reviewed as it impacted on activities for residents as did staff breaks. There were also a number of vacancies in the centre due to planned and unplanned leave. The provider was in the process of recruiting staff to address these vacancies.

The oversight and management of staff training records needed to be reviewed as the records viewed by the inspector were incomplete. At the time of the inspection a number of refresher training was planned for the coming weeks and months. However, the inspector found that some of this refresher training had been out of date since 2019.

The management of records stored in the centre required review, some of the records stored were not dated and some residents records were not detailed. For example; the vaccination status of a resident for a pneumonia vaccination was recorded as no records found, with no follow up attached to this.

Regulation 14: Persons in charge

There was a full time person in charge who was also responsible for two other designated centres. They were appointed to this role in October 2022. To support the person in charge a clinic nurse manager (CNM) was assigned a large number of responsibilities to oversee the care and support of residents in the centre. The inspector found that this was not sufficient as the CNM only had twelve hours protected time in order to complete maintenance lists, audits, staff rotas, supervision of staff and coordinate the care and support to residents. Some weeks due to staff shortages that twelve hours protected time was not available.

The inspector was therefore not satisfied that the registered provider had the appropriate arrangements in place to support the person in charge when they were responsible for more than one designated centre.

Judgment: Not compliant

Regulation 15: Staffing

There were a number of vacancies in the centre due to planned and unplanned leave. The provider was in the process of recruiting staff to address these vacancies.

There was a planned and actual roster in place on the day of the inspection.

however, there was a shortfall of staff in the centre on the day of the inspection as one staff had taken unplanned leave. This needed to be reviewed as the inspector was informed by staff that activities outside of the centre were sometimes impacted by a shortfall of staff or the times when staff breaks were scheduled meant that there were not sufficient staff to meet residents needs.

Staff spoken with said they felt very supported in their role and were able to raise concerns to the person in charge, if needed. Staff demonstrated a good knowledge of the residents a shortfall of staff or staff breaks which sometimes affected residents leaving the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The oversight and management of staff training records needed to be reviewed, the records viewed by the inspector were incomplete as they were not all up to date. At the time of the inspection refresher training for staff was planned for the coming weeks and months. However, the inspector found that some of this refresher training had been out of date since 2019 and 2021. For example; refresher training in safeguarding vulnerable adults, manual handling and basic life support.

While the person in charge had a plan in place going forward to ensure that staff received supervision, this was not the case prior to this inspection as required under the regulations and in line with the providers own policies and procedures.

Judgment: Not compliant

Regulation 21: Records

The management of records stored in the centre required review, some of the records stored were not dated and some residents records were not detailed. For example; the vaccination status of a resident for a pneumonia vaccination was recorded as no records found, with no follow up attached to this.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that the governance and management arrangements were not effective. While there was a defined management structure in place this was not

adequate.

There was ambiguity between managers and other personnel employed by the provider as to whether specific actions had been addressed on action plans, some of which could pose a risk to the residents safety of care. For example; none of these staff could confirm whether a contractor had been employed to deal with a specific risk in the centre. This had been reported to the maintenance department in December 2022.

The inspector raised concerns with a senior manager about the governance arrangements in place. For example the person in charge, clinical nurse manger (CNM), maintenance personnel or the person participating in management (PPIM) could not confirm whether a fire assessment had been conducted in the centre, and there was no report available to confirm this either. When the report was made available to the inspector at the end of inspection, the assessment had been completed in February 2022. The report identified 20 actions which required attention. This was very concerning as none of the managers had seen this report before the day of the inspection. This is discussed further under fire safety in section 2 of this report.

A quality and safety audit had been commissioned by the registered provider in December 2022, the inspector found that at this audit, a number of actions from the previous audits conducted in June 2022 had not been completed. For example; an easy read statement of purpose had not be developed for residents in the centre.

In addition, on review of some of the actions completed, the inspector found that some of the actions which had been signed off as complete had not been completed effectively. This was particularly evident under the risk management records viewed as discussed under risk management in the section 2 of this report.

Actions arising from audits or issues reported to maintenance were not been addressed in a timely manner. Some of the actions from the last inspection had not been implemented. For example; a risk assessment was due to be updated in relation to infection prevention and control and this had not been done.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a number of incidents that had occurred in the centre since the last inspection and found that the chief inspector had been notified where required under the regulations.

Judgment: Compliant

Quality and safety

Overall the inspector was not assured that residents were in receipt of a safe quality service in this centre, the poor governance and management arrangements in the centre were contributing to improvements being required in the premises, fire safety, risk management and infection prevention and control, personal plans, access to allied health professionals and the general welfare and development of residents.

Since the last inspection a number of actions from IPC audits had not been completed. Maintenance requests being submitted were not responded to in a timely manner. For example; a discussed earlier one resident had been waiting to have two pictures hung in their bedroom for 18 months and another had been waiting almost four months. An audit by the providers own employees had found that the laundry room and kitchen were not accessible to all of the residents. The registered provider was in the process of instigating a plan to address this.

Areas of the centre which required painting had not been completed. A window in the centre which was identified as a risk had been broken since 2021 and had not been fixed.

While the registered provider had systems in place to manage risks in the centre, the inspector was not satisfied that all risks were either risk assessed or where they were that they were reviewed adequately.

The fire safety arrangements did not provide assurances on the day of the inspection that these were safe or effective. The day after the inspection an urgent action plan was issued to seek assurances around this.

The provider had systems in place to manage IPC however, this area continued to require significant review particularly given that actions from audits were not addressed.

The general welfare and development of residents needed to be reviewed to ensure that residents had access to meaningful activities in the centre and outside of the centre.

Regulation 13: General welfare and development

On the day of the inspection residents were observed to be engaged in limited activities in the centre. A review of a sample of the residents records showed that activities were very limited in the centre. For example; one residents had a number of things they liked to do like; baking karaoke and dancing, a review of this resident's activity list showed that none of these activities were planned on the

activity plan.

Judgment: Not compliant

Regulation 17: Premises

The premises were for the most part clean, however, audits conducted had identified actions that had not been completed to the premises.

An audit by the provider had found that the laundry room and kitchen were not accessible to all of the residents. The registered provider was in the process of instigating a plan to address this at the time of this inspection.

Some work had been completed since the last inspection to the outside pathways after residents had made complaints about the surfaces. The inspector found that this required further review as only small areas outside the centre had been addressed.

Judgment: Not compliant

Regulation 26: Risk management procedures

While the registered provider had systems in place to manage risks in the centre, the inspector was not satisfied that all risks were either risk assessed or where they were in place; that they were reviewed adequately. For example; there had been a number of maintenance issues reported that were a potential risk to residents. These included bed rails which were observed to be frayed and could cause a potential injury to the residents when transferring in an out of bed. This had not been risk assessed or addressed at the time of the inspection.

There were two reports made which could indicate or cause a risk of rodent infestation, yet there was no documents to verify whether a contractor had called to the centre to address this. None of the staff or other employees in the maintenance department could verify this either. The inspector had requested verification of this before the end of the inspection and this was not provided. Written evidence was submitted after the inspection which indicated that a contractor had inspected the premises and had completed follow up visits to the centre, however, no staff were aware of this on the day of the inspection.

Following the last inspection a risk assessment in relation to the management of an infection prevention and control issue was due to be reviewed. However, the inspector found limited evidence of this review.

Other risk assessments reviewed contained information that was out of date

therefore the inspector was not satisfied that there was appropriate oversight over risk management practices.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had systems in place to manage infection prevention and control. However, following the last inspection and audits conducted by the provider some actions had not been addressed. For example; it had been identified in June 2022 that the curtains in the dining room needed to be taken down and washed. This had not been completed.

Following an outbreak of COVID-19 in the centre, the registered provider had not conducted a review to see if there was any learning from the event.

The vaccination status of residents was not clearly recorded in all of their files. When the inspector enquired whether residents had received a vaccination for pneumonia the staff were not clear about this. This was concerning given that some of the residents were in the age profile to be offered this vaccination.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire safety arrangements did not provide assurances that the systems in place were safe or effective. The day after the inspection an urgent action plan was issued to seek assurances around this.

The fire drill records indicated that a full time evacuation of the centre had taken over 14 minutes. The fire evacuation plan stated that a horizontal evacuation was conducted in order to assure a safe evacuation of the centre. Based on the position of fire containment doors the inspector was not satisfied that staff were fully able to explain how residents would be evacuated at night.

A day time evacuation of the centre had been conducted on three occasions over the last year, all of the fire drills had been completed in under one minute. The inspector was not assured that these times were accurate given the mobility needs of the residents.

The inspector also found that there was no records to indicate if the emergency lighting and fire doors had been serviced as required every quarter. These documents had to be requested by the inspector even though the issue had been raised at an earlier fire audit on 5 January 2023. The inspector found that this fire

audit was not effective, the auditor had assessed the centre as 88% compliant even though there were issues with fire doors, service records and the emergency response plan.

A visual inspection of some of the fire doors found that some of them required repair or replacement. The registered provider had commissioned a fire specialist to conduct a full review of the centre in February 2022. This report was only made available to the inspector at the end of the inspection, and had been the first time the registered provider had seen it. This report highlighted approximately 20 actions that required attention including fire doors.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An audit had been conducted by the provider on residents' personal plans. One residents assessment of need was due to be updated since June 2022 and this had not been completed at the time of this inspection. Actions from other audits of personal plans had not been completed even though the time frame for completion was relatively soon. For example; one residents plan had been audited on the 5 January 2023 where 20 actions had been identified and only nine had been completed at the time of this inspection. The inspector was therefore not satisfied at the time of the inspection that residents' personal plans contained the most up to date information.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported with their health care needs and for the most part had timely access to allied health professionals in order to support their needs. However, some residents had not been reviewed by a dentist, this had been highlighted by the provider through their own audits but no plan was in place at the time of this inspection to resolve this issue.

Judgment: Substantially compliant

Regulation 8: Protection

Staff had completed training in safeguarding vulnerable adults (although some

refresher training was outstanding) and were aware of the different types of abuse and who to report them to. Prior to this inspection, the registered provider had notified the chief inspector about a safeguarding concern in the centre. The inspector followed up on the actions the provider had taken following this and was satisfied that the provider was taking appropriate actions to address this.

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	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Whitmore Lodge OSV-0005811

Inspection ID: MON-0034486

Date of inspection: 18/01/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The Governance of the Designated Centre's under the remit of the PIC has been reviewed and the larger centers will have 1 WTE PIC per centre. Until the recruitment process has been fully completed the house managers in the large centers will be 37.5 hours supernumerary.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Additional permanent staff have been assigned to the centre. The On Call panel of staff has been expanded to allow for replacement of staff should a permanent staff member take unplanned leave. This has reduced the need for agency staff. The roster in the centre has been reconfigured and changed to a community model, whereby staff breaks no longer impact on opportunities for residents to leave the centre.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Staff training records have been reviewed and updated. All staff who were out of date on the day of the inspection in refresher mandatory training will have this training completed by 7/3/2023

Training is reviewed weekly at PIC, & Management

A review group has been established to look at the method of recording training within the service.

All staff have received informal supervision.
All staff will have formal supervision by 17.03.2023

A staff meeting has been held with the PIC and Management to address the findings of the inspection and to outline the culture changes necessary within the designated centre

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
All records in residents IPP's were audited and actioned. All records are now signed and in date.

The pneumonia vaccination status of all residents has been reviewed by GP and actioned if required.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A full review of all risk has occurred in the centre. The PIC has updated the Risk Register and reviewed all risk assessments. Risk assessments will be reviewed weekly at the PIC, at their Management meeting.

All maintenance issues are being addressed weekly by PIC with management. A new software maintenance package which allows for requesting tracking and reviewing maintenance issue is being purchased by the service.

All actions from internal audits have been actioned.

A full review of all actions identified in the external fire audit took place on 15.2.2023. and all identified issues discussed and plan to have all actions completed by 21.04.2023.

All audit findings in relation to IPP's of resident's records have been actioned with a quarterly audit schedule put in place by the PIC to ensure consistency of review.

An Easy Read Statement of Purpose has been developed for the centre.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
A full review of all activities and opportunities available to the residents in the centre has occurred. A schedule of meaningful activities has been put in place with opportunities for meaningful engagement both inside the centre and within the wider community.

A Coffee Doc area has been developed within the centre to allow for 1:1 engagement in a social setting to complement also visit to the community.

A salon/tranquility room has been developed to offer further opportunities within the centre.

The conservatory area has been recommissioned to include space for arts and crafts and growing seeds and engaging with gardening. This will be used in conjunction with the outside developed sensory garden.

All staff have received retraining in Person Centered planning, goal setting & meaningful engagement in community activities.

New Transport has been assigned to the centre to ensure community activities.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All actions from internal, HIQA & Maintenance audits are in process, completed or closed off.

The new upgrade kitchen has been designed and planned work has commenced will be completed by 29th April.

The coffee doc area will be used in the interim to support residents become involved in food preparation.

The development of the utility room and laundry has also been scheduled for completion by 29th April.

The instillation of a pathway where road is uneven has been commissioned with a completion date of 31st March 2023

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A full review of all risk has occurred in the centre. The PIC has updated the Risk Register and reviewed all risk assessments. Risk assessments will be reviewed weekly at the PIC, at their management meeting.

All outstanding maintenance in relation to risk to residents have been completed.

A schedule of visits from pest control company is in place and a record of visits is available.

A review of a covid risk assessment in relation to a staff member has occurred with all controls in place.

All painting required has been actioned.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All actions from previous audits in terms of infection prevention and control have been addressed. The curtains in the centre have been washed.

A post covid outbreak review has occurred, and learnings outlined.

The vaccination status of residents is clearly documented. The Pneumonia vaccination has been discussed with each residents GP and was offered where indicated.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A night-time fire drill took place early morning of 23.01.22 this was observed by both PPIM and Management and all learning documented along with all resident PEEPs being updated. Time of Horizontal evacuation into place of safety 9 min and 10.14 mins to external of building. (This was evacuation by hoist)

A daytime fire evacuation took place and all learning documented and Peeps reviewed following same. This evacuation took 2.5mins into place of safety.

One resident has been assigned a more suitable bedroom for fire evacuation purposes and both residents keyworkers involved residents & circle of support in this decision.

All staff were who took part in the evacuation drills were retrained in Horizontal evacuation 23.01.23

Fire consultant attended the Designated Centre on 24.01.23 to retrain all other staff on Fire evacuation with specific emphasis on Horizontal evacuation.

The Fire Safety Risk assessment is updated on the risk register.

This DC was fully rewired in 2011 and the DC had electrical modifications done in 2018 which were all certified. The next Periodic test and PAT test will be carried out by 01.03.23

Emergency lighting was inspected 03.11.22, and the cert is in the fire folder.

Fire detection and Alarm system was inspected 03.11.22, and the cert is in the fire folder.

Firefighting equipment was inspected May 2022 and the cert is in the fire folder.

The boiler for the designated centre was last serviced on 12.10.22

All Means of escape routes cleared of any possible hazards.

All fire doors closures were checked to ensure they provide the required fire performance

23.01.23

The two double fire doors in hallway at back and front door exits are measured for replacement Fire doors

Fire documentation Audit was reviewed, and the audit form is being updated to ensure greater clarity.

All recommendation of the Fire consultant risk assessment is in action and will be completed by 21.04.23.

A bespoke manakin has been ordered and will be available in the centre by 8/4/2023 to ensure that night-time fire drill can be conducted with use of ski sheets.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
An audit of all Individual Personal Plan has occurred, and all identified actions completed.

There is a quarterly schedule of audit in place for 2023.

All assessments of need for each resident have been updated.

Staff in the centre have received supervision regarding the importance of reviewing and updating residents' records.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents have dental reviews scheduled, this will be completed by 03.05.2023

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	27/03/2023
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	27/03/2023
Regulation 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance,	Not Compliant	Orange	17/03/2023

	operational management and administration of the designated centres concerned.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/01/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	07/03/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	17/03/2023
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.	Not Compliant	Orange	29/04/2023
Regulation 17(5)	The registered provider shall ensure that the premises of the	Substantially Compliant	Yellow	29/04/2023

	designated centre are equipped, where required, with assistive technology, aids and appliances to support and promote the full capabilities and independence of residents.			
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/01/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	03/03/2023
Regulation 23(1)(c)	The registered 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	Not Compliant	Orange	21/04/2023

	and effectively monitored.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	03/03/2023
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	31/01/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	21/04/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health	Substantially Compliant	Yellow	24/02/2023

	care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	03/05/2023