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:	Dundalk Supported Accommodation
Name of provider:	The Rehab Group
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	21 February 2023
Centre ID:	OSV-0003405
Fieldwork ID:	MON-0030957

About the designated centre

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

The designated centre is a two storey detached house with five bedrooms in close proximity to a large town in County Louth. The service can accommodate up to five adults with disabilities. Each resident has their own bedroom (one en-suite) and communal facilities include a kitchen cum dining room, a sitting room, a sun room, a utility facility and communal bathrooms. There is a garden to the rear of the property and adequate on-street and private parking is available. Transport is also available to residents if required. The staffing arrangements consist of a person in charge, a team leader and a team of support workers. Staff are available to provide support in the evenings and morning times with, a sleepover staffing arrangement provided at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 21 February 2023	10:10hrs to 18:40hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, residents were receiving a person centred service that met their assessed needs. A number of improvements were required with regard to fire precautions. Additionally some improvements were required in relation to positive behaviour support, training and staff development, premises, governance and management, and risk management procedures. These will be discussed further throughout the report.

The inspector had the opportunity to meet all four residents who lived in the centre. Three had attended an external day program that day and one resident had attended their paid employment. Each resident communicated to the inspector that they had a nice day. Three residents planned to relax for the evening and watch television. One resident left to participate in a exercise class and another resident walked to meet them after their class to keep them company on their walk back. Some residents spoken with said they were happy living in the centre and that the staff who worked there were nice. Two residents spoken with told the inspector how they could raise an issue or concern to a staff member or the person in charge if they were unhappy about anything.

The team leader for the centre along with another team leader from another centre facilitated the inspection as the person in charge was on leave. In addition to two team leader, there were two staff members on duty during the day of the inspection. The team leader and a staff member spoken with demonstrated that, they were familiar with the residents' support needs and preferences.

The inspector observed that overall, the physical environment of the house was clean and for the most part, in good decorative and structural repair. Some minor decorative, repair and replacement works were required in some areas around the property. For example, some of the garden furniture required to be painted and some of the chairs required repair.

Each resident had their own bedroom and one resident had an en-suite facility. There was sufficient storage facilities for their personal belongings in each room. Residents' rooms were decorated to their personal choices and each room had personal pictures displayed. Two residents offered to give the inspector a tour of their bedrooms and appeared proud to show off their rooms.

The centre had an adequate sized back garden with garden furniture. One resident told the inspector that there were plans to get a new outside cabin which would be operated as a gym for the residents. They showed a picture on the notice board of an example of the cabin.

The inspector observed some interactions between staff members and residents and they appeared to be relaxed and person centred. Communication at meal preparations was observed to be friendly and encouraging. The inspector observed

two residents making their own separate meals of choice that evening.

As part of this inspection process residents' views were sought through questionnaires provided by the Health Information and Quality Authority (HIQA). Feedback from the questionnaires returned was provided by way of the residents themselves. Three of the residents indicated that they were happy with all aspects of the service they received. One resident was happy with a lot of the service they received but noted that some things could be better. For example, some areas they felt could be better related to, do you feel safe, is it a nice place to live, staff and managers listen to me, and things that affect me are always discussed with me.

The inspector also had the opportunity to speak to one family member in person, they stated that they felt comfortable raising any concerns they had to the person in charge or a staff member. They felt that when they did raise a concern that their feedback was taken on board and efforts made as a result. There was a recent change to the way in which meals were being considered and prepared. Each resident was now completing their own personal food shop and being supported to cook their own meals each evening. The family member was happy for this new method to be trialled in order to encourage meal preparation and cooking and to ensure a balanced diet.

The provider had also sought resident and family views on the service provided to them by way of six-monthly unannounced visits to the centre and through an annual questionnaire. Feedback received indicated that residents and families communicated with were happy with the service provided. One family member had asked to be communication with through email instead of over the phone and this request was respected by the centre staff.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was undertaken following the providers application to renew the registration of the centre. This centre was last inspected in June 2021 where it was observed that some minor improvements were required to ensure the centre was operating in full compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). Actions from the previous inspection had been completed by the time of this inspection.

Overall, the provider and person in charge had ensured that there were effective systems in place to monitor the service and provide a good quality service to residents. However, improvements were required in training and staff development

and governance and management.

There was a defined management structure in place which included the person in charge and a team leader. They both provided leadership and support to their team and knew the residents well.

The provider had completed an annual review of the quality and safety of the service for 2021 and the review for 2022 was due to be completed at the time of the inspection. In addition, they had carried out unannounced visits twice per year. There were other local audits and reviews conducted in areas, such as monthly vehicle audits and an annual health and safety audit.

The provider identified that there were incompatibility issues between some residents. While they had put measures in place to help alleviate some of the potential causes of the incompatibility, the issues were still on-going for the last year. The incompatibility at times was causing anxiety or stress for the residents.

A review of the rosters demonstrated that the skill-mix and numbers of staff was adequate to meet the assessed needs of the residents. The provider had increased staffing numbers last year to ensure a second staff was available for portions of each day when four residents were present. This was in order to promote positive relations between residents.

There were supervision arrangements in place for staff as per the organisation's policy. However, from a small sample of staff supervision files reviewed not all supervision was taking place within the frequency as prescribed by the provider.

The person in charge monitored staff training and development needs and they ensured that staff had access to a suite of training and development opportunities, for example, safeguarding of adults. However, from the evidence presented to the inspector on the day, some staff were due training, for example, in supporting behaviours that challenge.

Each resident had a contract of care in place and it included information regarding any fees to be charged to residents.

The inspector reviewed the arrangements in place for complaints. There was a complaints policy and procedure in place. Residents and families were supported to make complaints where they chose to, and a record of these was maintained.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced. The person in charge worked in a full-time role and managed two centres. They were supported in each of the centres by a team leader. The person in charge split their time evenly between the two centres.

Judgment: Compliant

Regulation 15: Staffing

The staffing arrangements were found to provide continuity of care to residents. Staff had the necessary skills and experience to meets residents assessed needs.

The provider had increased staffing numbers in 2022 to ensure a second staff was available for portions of each day when there were four residents present. This was in order to ensure residents had choice about their day and to try to promote positive relations between residents.

Staff personnel files were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There were supervision arrangements in place for staff as per the organisation's policy. However, from a small sample of staff supervision files reviewed, not all supervision was occurring within the frequency as prescribed by the provider.

The person in charge monitored staff training and development needs and there was a staff training grid to provide high level oversight of the training needs. The person in charge had arranged for the majority of staff to receive training in human rights and there were plans for all staff to receive this training. However, from the evidence presented to the inspector on the day some staff were due some mandatory training, for example, in fire safety, supporting behaviours that challenge and one staff was due a refresher in hand hygiene.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a defined management structure in place which included a team leader who reported to the person in charge, who in turn reported to an integrated service manager.

The provider had completed an annual review of the quality and safety of the service and had carried out unannounced visits twice per year. The annual review and the unannounced visits provided for consultation with residents and their family

representatives. There were other local audits and reviews conducted in areas, such as medication management and finance. In addition, the person in charge facilitated regular team meetings to occur.

The provider had identified that there were incompatibility issues between some residents. They had put measures in place to help alleviate some of the potential causes of the incompatibility issues. For example, additional staffing, behaviour therapy input and redecorating the sun room to be a more inviting second space for residents. However, the issues were still on-going for the last year and they were causing stress and anxiety to residents at different times.

In addition, the provider's own audits had not identified some of the issues in relation to fire precautions as found by the inspector. Furthermore, while fridge temperatures were being recorded daily there was no evidence of any actions taken when there was repeated high temperatures recorded.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Each resident had a contract of care in place and they included information regarding fees to be paid by residents. Resident representatives had the opportunity to sign the contract of care. The person participating in management confirmed that the contracts were currently under review in order to reflect changes in fees charged to the residents. This was with regard to the new system for food shopping and meals being trialled as previously discussed. No other aspect of this regulation was reviewed on this inspection.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. There was a complaints policy, and associated procedures in place. An accessible version of the policy was available for residents. There had been an number of complaints in the centre mainly due to incompatibility issues between the residents. Any complaints made had been recorded, reviewed and efforts had been made to resolve the complaints. Incompatibility issues between residents is being dealt with under Regulation 23: Governance and management.

Judgment: Compliant

Quality and safety

Residents were receiving appropriate care and support that was individualised and focused on their needs. However, as previously stated improvements were required with regard to fire precautions and minor improvements were required with regard to positive behaviour support, premises and risk management procedures.

While the provider had fire safety management systems in place on the day of the inspection a number of improvements were required. The inspector observed a number of improvements to the fire containment measures following a walk around the centre. For example, one fire containment door did not have a self-closing device fitted. In addition, from a review of documentation, improvements were required to the detection system in place to ensure it covered all applicable areas and that all emergency lighting was meeting current requirements. This included, the alarm detection system not covering the attic space. It was communicated to the inspector that, while the person in charge had submitted some of the issues to the housing association there was no date for any actions.

Each resident had an assessment of their health and social care needs completed. Those assessments, along with residents' support plans, were under regular review and multidisciplinary professionals were involved in the development of care being provided as applicable.

The person in charge was promoting a restraint-free environment and there were no restrictive practices used within the centre. Residents had access to specialist support to understand and alleviate the cause of any behaviours that may put them or others at risk. However, one behaviour support plan in place was over due a review to ensure all information contained within the plan was still applicable.

There were arrangements in place to protect residents from the risk of abuse, including an organisational policy. There was an identified designated officer, and it was found that any concerns in the past of potential abuse were screened and reported to relevant agencies. There were some open safeguarding concerns at the time of the inspection and the provider had safeguarding plans in place to help mitigate potential risks.

The centre was being operated in a manner that promoted and respected the rights of residents. Residents were being offered the opportunity and independence to engage in activities of their choice and how they spent their day.

Visits were facilitated with no visiting restrictions in place in the centre. In addition, there were a couple of areas available for entertaining visitors in private if required.

There was a residents' guide in place and a copy was available to each resident, the guide contained the required information as set out in the regulations.

The premises was homely and observed to be very clean and tidy. However, some

minor improvements were required to the paintwork of some areas, cleaning schedules and repair of replacement of some areas to ensure they were conducive to cleaning. For example, a small area of a radiator was rusted.

There was a policy on risk management and associated procedures in place. In addition, there were centre and individual risk assessments on file with control measure listed. However, some minor improvements were required with regard to the risk oversight document and some risk assessments to ensure all documents were an accurate reflection of what was happening in the centre.

The inspector reviewed matters in relation to infection control management in the centre. The provider had systems in place to control the risk of infection both on an ongoing basis and in relation to COVID-19. For example, colour coded chopping boards, cloths and mop heads in order to help prevent cross contamination. As previously stated there were some minor issues identified in relation to cleaning checklists and to ensure some areas were conducive for cleaning and they are being dealt with under Regulation 17: Premises.

Regulation 11: Visits

Visits were facilitated with no visiting restrictions in place in the centre. Residents were supported to maintain contact with their family and friends. For example, some residents regularly visited their family home and families were welcome to visit the centre. There were two available private areas for entertaining visitors.

Judgment: Compliant

Regulation 17: Premises

The premises was homely and observed to be very clean and tidy. However, some minor improvements were required to the paintwork of some areas, for example, some communal areas and a resident's bedroom. Some areas required repair or replacement, for example, the garden furniture required painting and repair to the wooden slats and the downstairs water closet pedestal required replacement as it was only a temporary one in place.

In addition, some areas required repair or replacement to ensure they were conducive to cleaning, for example, the surface of some locks on doors was damaged and a radiator had a small rusted area. Furthermore, the cleaning checklists for the centre were not always being completed as per the frequency of the document as the were many gaps observed in the recording of the information.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide in place and a copy was available to each resident which contained the majority of required information as set out in the regulations. Any omitted information was amended and evidence shown to the inspector.

Judgment: Compliant

Regulation 26: Risk management procedures

For the most part there were appropriate systems in place to manage and mitigate risks and keep residents and staff members safe. For example, there was a risk management policy in place and there were centre specific and individual risk assessments developed with control measures in place as required. In addition, the inspector observed that the centre's vehicle was insured, serviced and had an up-to-date national car test (NCT).

However, there were some documentation issues observed with regard to risk assessments and the centre's risk register. From the evidence provided to the inspector on the day, not all identified and assessed risks were recorded on the centre's risk register which acted as the centre's risk oversight document. Some control measures in place were not recorded on the applicable risk assessment, for example, with regard to lone working.

In addition, one particular resident with some health vulnerabilities, did not have a risk assessment for staying alone for periods in the centre. Additionally, one risk was not robustly risk assessed with regard to staff not wearing masks in the centre at the time of the inspection.

Furthermore, some risk assessments that were no longer applicable were still contained within the risk management folder, for example, staff to wear masks in the centre and vehicle with regard to COVID-19.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were measures in place to control the risk of infection in the centre, both on an ongoing basis and in relation to COVID-19. There were hand washing and

sanitising facilities available for use and infection control information and p0rotocols were available to guide staff.

There was a contingency plan in the event of an outbreak of an infectious illness which included a staffing contingency plan and isolation plans for residents. The person in charge had recently completed a self-assessment tool against the centre's current infection prevention and control (IPC) practices. In addition, the centre had received an IPC audit by a person external to the centre in January 2023 which identified some of the same issues as the inspector. The person in charge had reported any premises issues to the housing association board and was awaiting dates for repair or replacement.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management, for example, the centre had fire safety equipment in place which was regularly serviced. Fire evacuation drills were taking place which included a drill with maximum numbers of residents participating and minimum staffing levels.

However, a number of improvements were required which included:

- the fire alarm system in place did not cover the attic space
- one fire containment door would not close fully by itself
- two fire containment doors did not have intumescent strips or cold smoke seals fitted
- the inspector could not ascertain if some downstairs doors were fire containment doors, for example, a resident's bedroom door and there was no inventory of fire containment doors available for the inspector to verify the doors
- one fire containment door did not have a self-closing device fitted
- the emergency light on the landing had failed testing completed by an external contractor since May 2022
- an external contractor had recommended since December 2022 that further emergency lighting was required in order to comply with current standards.

It was communicated to the inspector that while the person in charge had submitted some of the issues to the housing association there was no date for any actions.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need completed and there were personal plans in place for any identified needs. Personal plans were reviewed at planned intervals for effectiveness. For example, there was a plan in place for a specific healthcare need for a resident.

In addition, residents were supported to develop life goals for themselves to work on for the coming year. For example, one resident wanted to undertake a creative writing course and also join a walking group. Another resident wanted to go on a break away to a specific spa.

Judgment: Compliant

Regulation 6: Health care

Residents' healthcare needs were assessed and appropriate healthcare was made available to each resident. For example, they had access to a general practitioner (G.P) and a wide range of allied health care services, such as neurology and chiropody. In addition, residents were supported to receive COVID-19 and flu vaccines.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge was found to be promoting a restraint free environment and there were no restrictive practices in place.

Where necessary, residents received specialist support to understand and alleviate the cause of any behaviours that may put them or others at risk. However, one behaviour support plan was overdue a review.

Judgment: Substantially compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse, for example, staff were appropriately trained in adult safeguarding. Staff spoken with were familiar with the steps to take should a safeguarding concern arise. There were open safeguarding issues within the centre and there were safeguarding plans relating to each. Actions from the safeguarding plans were in place within the centre. The provider was working on solving the incompatibility issues within the

centre that were causing the safeguarding concerns, however, the issues remained on-going at the time of this inspection. This is being dealt with under Regulation 23: Governance and management.

Residents were independent around their own intimate care. In addition, residents were encouraged to be independent with their own finances with three residents independently managing their money and another supported by their family as per their wishes. The team leader or the person in charge completed monthly financial audits.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were facilitated and empowered to exercise choice and control across a range of daily activities and had their choices and decisions respected. There were weekly residents' meetings whereby the residents chose what house chores they would be responsible for that week and what activities they may like to participate in. Two residents spoken with told the inspector that they get choices about their day, what they eat and they chose how their room was decorated. Residents were encouraged to be independent with their medication management and with their finances.

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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially 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 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Dundalk Supported Accommodation OSV-0003405

Inspection ID: MON-0030957

Date of inspection: 21/02/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: - One relief staff member who is currently on leave has yet to finish all outstanding training and will complete on return. - All supervisions are up to date as per schedule. Completed 20/03/23	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: - Fridge Temperatures – New fridge has been purchased and it is reading correct temperatures. Discussed at Staff meeting on the 20/03/23 to ensure correct temperatures is maintained and procedure if not correct. PIC and Team leader completing spot checks and documenting same on monthly audits. - Compatibility – The provider will continue to monitor and follow safeguarding plan. PIC has contacted HSE for another meeting to explore options going forward. - Fire – PIC has signed up to a new online system with current provider in order to be able to review work reports on the day it is completed. PIC and team leader will monitor this and record in monthly audits if any issues arise to ensure that it is actioned immediately.	

- PIC has also signed up for Fire contractor to come in every six months to do a fire door check to ensure that all fire doors are in order.

- Self Closure doors and emergency lighting will continue to be checked daily/weekly as part of the fire safety checks.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Areas that need paintwork will be completed by 01/09/23.
- Garden Furniture – PIC and team leader spoke with resident's; it has been agreed that the existing of set would be disposed of and a new set will be purchased for use in the summer months.
- Locks on doors were replaced on 31st March 2023.
- Rusted radiator was painted on 30th March 2023.
- New cleaning schedule due to commence on 3rd April 2023. The PIC has discussed the cleaning schedule with staff and outlined the importance of ensuring there are no gaps in the cleaning and that the schedule is consistently implemented, this was completed on 20/03/23. The implementation of the revised cleaning schedule will be monitored on a weekly basis by the Team Leader.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
- The Risk Management Framework has been updated to outline the function of the risk register and the service level risk log and how these are used to provide oversight of risks in the service. - Residents risk assessment in respect of staying alone in the service was completed on 20/03/23. - Risk assessment on Mask Wearing was completed on 20/03/23. - Lone Working risk assessment completed and discussed with both residents and staff on 22/03/23.
- All control measures in all risk assessments will be reviewed to ensure all controls are documented this will be completed by 30/04/23.
- Risk Assessment which are no longer applicable were archived on the 22/03/23.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Newgrove housing has given the PIC written assurance that all the below works will be completed by the 01/07/23.
• the fire alarm system in place did not cover the attic space
• one fire containment door would not close fully by itself
• two fire containment doors did not have intumescent strips or cold smoke seals fitted
• the inspector could not ascertain if some downstairs doors were fire containment doors, for example, a resident's bedroom door and there was no inventory of fire containment doors available for the inspector to verify the doors
• one fire containment door did not have a self-closing device fitted
• the emergency light on the landing had failed testing completed by an external contractor since May 2022
• an external contractor had recommended since December 2022 that further emergency lighting was required in order to comply with current standards.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
- Resident’s Behavioral Support Plan was updated by the BT on the 28/02/23.

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	14/04/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	20/03/2023
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.	Substantially Compliant	Yellow	03/04/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Substantially Compliant	Yellow	01/09/2023

	designated centre are clean and suitably decorated.			
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 and effectively monitored.	Substantially Compliant	Yellow	01/07/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/04/2023
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	01/07/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/07/2023
Regulation 07(3)	The registered provider shall ensure that where required,	Substantially Compliant	Yellow	28/02/2023

	therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			