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:	A2
Name of provider:	Peamount Healthcare
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	15 February 2023
Centre ID:	OSV-0005387
Fieldwork ID:	MON-0039224

About the designated centre

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

The designated centre is comprised of three individual units and is located on a shared campus setting in West County Dublin. It provides 24-hour residential support services to persons with intellectual disabilities and at the time of inspection was supporting 13 individuals. The three units of the centre had similar layouts and included an entrance hallway, a living and dining room, a small kitchen area, accessible bathrooms and individual bedrooms for residents. The staff team was comprised of a person in charge, a social care leader, staff nurses, carers, an activity coordinator and household staff members.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 15 February 2023	09:20hrs to 17:45hrs	Marie Byrne	Lead
Wednesday 15 February 2023	09:20hrs to 17:45hrs	Karen Leen	Support

What residents told us and what inspectors observed

This unannounced inspection was completed to monitor ongoing compliance with the regulations and standards. Overall, the findings of this inspection were that steps taken by the provider since the last inspection had improved the levels of compliance with the regulations. For example, improvements were found in relation to staff training and development, the oversight of residents' finances, and risk management in the centre. However, additional actions were required to ensure that residents were in receipt of a good quality and safe service. For example, in line with the findings of previous inspections improvements were required in relation to staffing, residents' access to activities, the premises, and fire safety in the centre. In addition, some documentation required review to ensure consistency in terms of residents' care and support needs and in order to ensure it was clearly guided staff practice. An urgent action plan was issued to the provider by the Office of the Chief Inspector of Social Services after the inspection in relation to fire safety and this will be further discussed later in the report.

The inspectors of social services visited the three houses that make up this designated centre during the inspection, and had the opportunity to meet 10 of the 12 residents living there. Due to their communication needs and preferences some residents did not verbalise their opinions on care and support in the centre. However, some residents did and they spoke with inspectors about their favourite meals, things they liked to do, and their home. The inspectors also used observations, discussions with staff, and a review of documentation to find out what supports were in place for residents in the centre.

Throughout the inspection residents appeared comfortable in their homes and with the levels of support offered by staff. Staff were observed to listen to residents' requests and respond appropriately, and to pick up on their non verbal cues also. However, from speaking with residents and staff and a review of a sample of staff rosters in the centre it was not evident that there were enough staff to meet the number and needs of the centre. In addition, improvements were required to continuity of care and support for residents.

On arrival to each of the three houses the inspectors were directed by staff to areas where the visitors' book, hand sanitizer and personal protective equipment was available. Each of the houses were found to be clean, warm and well maintained during the inspection. There were issues relating to the storage of large items, particularly in one of the houses and this will be discussed later in the report. Residents' bedrooms were personalised and found to contain their personal items and photos. Communal areas were well furnished and contained soft furnishings which contributed to the homeliness of the houses.

Inspectors had an opportunity to observe the mealtime experience for a number of residents and were present in two of the houses when dinner was being cooked. Huge efforts were being made by staff to prepare and cook meals for residents in

the houses every day. Residents were involved picking the items on the shopping list, and doing the shopping if they so wished. They could also take part in preparing and cooking meals if they wished to. There was a pleasant and relaxed atmosphere in the houses at these times. However, in one of the houses, there was one staff on duty and they were observed to be very busy. They were starting to cook the dinner while also supporting a number of residents to have a hot drink. In another house staff had started meal preparation before supporting residents to go to mass and then came back to cook it.

The centre was located on a large campus in West Co. Dublin. There was a bus route within walking distance of the centre, and the provider had a number of vehicles to support residents to attend appointments and activities in their local community. There was a day service on the campus, and on the day of the inspection a number of residents were attending day services. A schedule of activities was sent to the houses by day service staff and included activities such as cooking, pottery, arts and crafts, and gardening. Residents could choose which activities they wanted to take part in. In addition, a number of residents were attending mass when inspectors visited their home. Inspectors viewed a number of residents' goals, daily handovers, residents' activities records and their daily records. They found that from the sample of documents reviewed some residents had limited access to activities outside their home, or off the campus. Inspectors did find that residents were supported to go on holidays in 2022 and plans were in place for 2023. In addition, staff spoke about how much residents were enjoying getting back to going to mass and day services now that restrictions relating to the COVID-19 pandemic had lifted.

Residents were supported to keep in touch with, and spend time with their family and friends if they wished to. There was limited private space available, particularly in one of the houses. The provider was aware of this and they outlined plans to inspectors to support residents to identify their wishes and preferences to move to alternative accommodation in line with their changing needs.

There were complaints policies and procedures in place and information was available for residents in their homes. Two residents told an inspector what they would do if they were unhappy with any element of their care and support. There was also information available on how to access independent advocacy services. There were hand hygiene and standard precaution relation posters on display and infection prevention and control (IPC) was regularly an agenda item at residents' meetings.

In summary, residents appeared relaxed and content in their home and with the levels of support offered by staff. They were supported to decorate their home and their rooms in line with their preferences. Regular staff were found to be familiar with residents' needs and preferences; however, improvements were required in relation to the number of staff employed by the provider and continuity of care and support for residents. In addition, improvements were required to ensure that residents were supported to enjoy activities they found meaningful, particularly in their local community, and to ensure that some of the documentation in place was

reflective of residents' care and support needs and guiding staff practice.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

While the provider had brought about improvements in terms of staff training and development, risk management, the oversight of residents' finances, further improvements were required to ensure that residents were in receipt of a good quality and safe service. There were clear lines of accountability and staff had specific roles and responsibilities. However, the centre remained under resourced in terms of staffing and this was found to be having a negative impact on the lived experience of residents in the centre. For example, inspectors found that there were not enough staff to meet the number and needs of residents living in the centre. This was found to be having an impact on continuity of care and support for residents and their access to activities outside their home. There were a number of staff vacancies and a high volume of different relief and agency staff covering shits in the centre.

As previously mentioned, an urgent action plan was issued to the provider after the inspection in relation to Regulation 28 Fire Precautions. This urgent action identifying a timeframe for returning it to the Chief Inspector. The provider submitted the urgent action plan in line with the identified timeframe and provided assurances in relation to the steps they had and were going to take to bring Regulations 28 into compliance in a timely manner.

The person in charge facilitated the inspection. They were found to be very familiar with residents' care and support needs and motivated to ensure that each resident was happy, well supported, and safe living in the centre. Residents were observed to be familiar with the person in charge, and staff were complimentary towards how they supported them to carry out their roles and responsibilities. The person in charge was supported in their role by a number of person participating in the management (PPIM) of the designated centre including an assistant director, and a director of nursing and social care.

Improvements were found in terms of staff accessing training and refresher training. In addition, staff were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities. From a review of a sample of staff supervision records they were resident focused and provided staff with opportunities to raise any concerns they may have in relation to residents' care and support.

Inspectors found that improvements were required to the oversight and audit of documentation in the centre. Records were in place and made available to

inspectors; however, some records were not found to be accurate or up to date. For example, conflicting information was found across documents in residents' personal plans in relation to their finances. Their money management assessment did not match their financial passport. In addition, fire safety related documents across folders in the centre and residents' personal plans differed, safeguarding plans did not contain review dates, where a residents' assessment of need stated they did not have positive behaviour support needs, they had a positive behaviour support plan in place and a risk assessment in place in relation to behaviours of concern.

Regulation 14: Persons in charge

The person in charge had the qualifications, skills and experience to fulfill the role. They were available to support residents and staff, and present in each of the houses regularly. Inspectors found that the person in charge was motivated to ensure that residents were happy and safe in their home.

Judgment: Compliant

Regulation 15: Staffing

From speaking with residents and staff, observations in the houses, and a review of rosters and staff supervision records, a review of residents' assessments, and of residents' activity records it was evident that there were not enough staff to meet the number and needs of residents living in the centre.

Inspectors were informed that there were 3.5 whole time equivalent (WTE) care staff vacancies and 0.5 WTE staff nurse vacancies at the time of the inspection. However, in addition to the vacancies a number of residents required the support of two staff at times. There was one staff on duty in each of the houses and a staff was shared amongst the three houses to provide assistance to residents and to cover staff breaks.

From a review of rosters for the centre, it was evident that residents were not in receipt of continuity of care and support. For example, over a one month period in the centre there were four shifts unfilled, 13 different agency staff covered 16 shifts, five shifts were covered by staff from different parts of the organisation, and 15 different relief staff covered 35 shifts.

Judgment: Not compliant

Regulation 16: Training and staff development

There was training and refresher training available for staff in line with the organisation's policy and residents' assessed needs. Staff were in receipt of regular formal supervision which was being completed by the person in charge. From the sample reviewed agenda items were resident focused and varied. Examples of agenda items included residents care and support and goals, safeguarding, residents' rights, fire safety, choices and privacy, areas where improvements could be made in the centre, care planning and keyworker duties, and staff training and development.

Judgment: Compliant

Regulation 21: Records

While the required records were in place and made available during the inspection, inspectors found that there were gaps and inconsistencies across a number of documents reviewed in the centre. Some of these gaps and inconsistencies could lead to a risk to residents due to the volume of shifts covered by different relief and agency staff in the centre. For example induction folders for new staff included out of date information, there was conflicting information relating to residents support needs in the event of an emergency.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that while the provider had systems in place for the oversight of care and support for residents these were not proving fully effective. For example, while the provider had completed six monthly reviews in line with the requirement of the regulations the latest one was completed in November 2022 but was not made available to the person in charge for their review or follow up. In addition, the provider's latest annual review did not include the input of residents or their representatives.

The were insufficient resources to meet the needs of residents, particularly relating to staffing numbers. This was found to be negatively impact on staff's availability to support residents to engage in activities and to ensure they could safely evacuate the centre in the event of an emergency.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was in place and available in the centre. It was being regularly reviewed and updated in line with the timeframe identified in the regulations and found to contain the required information.

Judgment: Compliant

Quality and safety

Overall, inspectors found that some improvements were required to ensure that residents were in receipt of a good quality and safe service. Residents were involved in the day-to-day running and upkeep of their home. Their rights were promoted and they appeared happy and content in their homes. However, as previously mentioned inspectors found that residents had limited opportunities to engage in activities outside of their home or off the campus. In addition, an urgent action was issued to the provided in relation to fire safety in the centre. Following the inspection the provider submitted an urgent action plan showing a number of responsive actions they had, and were planning to take in relation to fire safety.

Significant improvements were found in terms of the oversight and documentation relating to residents' finances since the last inspection. Receipts were available for their purchases and Each resident had a ledger recording their income and expenditure. Residents had an assessment in relation to their money management and a financial passport in place. There were some inconsistencies in some residents assessment and plans and this was captured under Regulation 21. From a sample of records reviewed by inspectors balances in residents' purses and wallets matched those in their financial ledgers.

As previously mentioned, the houses were warm, clean, and well maintained. Residents' bedrooms were personalised to suit their tastes and communal areas appeared comfortable and homely. There were issues identified in relation to storage, particularly storage for large items in the centre and this will be discussed further under Regulation 17.

Inspectors acknowledge that some residents were attending day services and from a review of documentation and speaking with residents and staff they were enjoying this. However, from reviewing records, through observations made by inspectors during the inspection, and speaking with staff some residents had limited opportunities to engage in activities outside of their home or off the campus. Examples of this will be discussed under Regulation 13.

Residents, visitors and staff were protected by the risk management and infection prevention and control policies, procedures, and practices in the centre. There was a

risk register and individual risk assessments were developed and reviewed as required. There were risk assessments and contingency plans in place in relation to infection prevention and control. Staff had completed a number of infection prevention and control related trainings and were observed to adhere to standard precautions during the inspection. Each of the three premises were clean and there were cleaning schedules in place to ensure each area of each house was regularly cleaned.

There was suitable fire equipment in place and evidence that it was being serviced and maintained. There were adequate means of escape and staff had completed fire safety awareness training. Fire drills were occurring in the centre and the provider had identified an issue in relation to the time it was taking in one of the houses for residents to evacuate safely. This had been highlighted and reviewed by the management team and health and safety team. They had reviewed systems and documentation; however, the timeframe identified by them as safe for this centre had not been reached at the time of the inspection. In addition, it was unclear from documentation reviewed where additional staff support would come from in the event of an emergency as this house was single staffed at times, and each resident required some form of support to safely evacuate the house.

Regulation 12: Personal possessions

There was evidence of improved oversight of residents' finances since the last inspection. Each resident now had a financial ledger to show their income and expenditure and these were being checked and reviewed regularly.

Residents have a financial passport and an assessment in place. There were inconsistencies across a number of residents' records reviewed and this was captured under Regulation 21.

Judgment: Compliant

Regulation 13: General welfare and development

From a review of a sample of residents' assessments, activity records and daily records inspectors found that some residents did not have regular opportunities to engage in meaningful activities outside their home, or off the campus. Some residents' records demonstrated that they has on average one to three outings outside the campus per month, and for one resident it was not evident that they had left the campus over a four week period. Examples of home-based activities recorded in some residents' personal plans included "rest in bed", "cleaning the table", "emptying the bin", "a drive", or "foot care".

Some residents had limited goals in place, and for others it was not recorded if their

goals had been achieved, or if they found it meaningful when they had achieved them.

Judgment: Not compliant

Regulation 17: Premises

The houses were found to be clean, homely, and overall well maintained. There was suitable heating, lighting and ventilation, a separate kitchen with cooking facilities, and suitable facilities for laundry and waste management. Records were maintained of the required repairs and maintenance works.

Rooms in the house were bright, airy and colourful. For some residents they had limited access to private and communal spaces. For example, in two of the houses residents had access to an additional communal area where they could spend their time or meet with their family or friends. However, this space was not available for residents in one of the houses. The provider was aware of this and outlined plans to support two residents to transition from this house in line with their changing needs, and their wishes and preferences.

There was limited storage for large items across the centre. This was particularly evident in one residents' bedroom there was two mobility aids, a chair, a wheelchair, and a fire evacuation aid. In a communal space in another house there was a sit on weighing scales and a number of suitcases.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide available in the centre. It contained the information required by the regulations, and was available in an easy-to-read format. It included a summary of the services and facilities provided to residents, the terms and conditions of residency, arrangements for resident involvement in the running of the centre, how to access inspection reports, the complaints procedures, and arrangements for visits.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the risk management policies,

procedure and practices in the centre. Inconsistencies were found in some risk assessments reviewed and these gaps were captured under Regulation 21. Inspectors found that the arrangements in place to ensure risk control measures were relative to the risk identified were suitable. There were measures in place to reduce or minimise the risk of accidents. There was evidence of oversight of accidents and incidents in the centre. Leaning following incidents was shared across the team at handover and in staff meetings.

Judgment: Compliant

Regulation 27: Protection against infection

Overall, residents, staff and visitors were protected by the infection prevention and control policies, procedures, and practices in the centre. The physical environment was found to be very clean in each of the three houses and there were systems in place to minimise the risk of the spread of infection. Staff were observed to adhere to standard precautions throughout the inspection.

There were risk assessments and contingency plans in place. There were stocks of PPE available and systems in place for stock control. There were also appropriate systems in place for waste and laundry management.

Staff had completed a number of infection prevention and control related trainings and there was information available for residents and staff in relation to infection prevention and control and how to keep themselves safe.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had completed significant fire safety works in the centre including installing fire doors and self-closing mechanisms. There were adequate means of escape and these were observed to be clear during the inspection. There was emergency lighting and illuminated signage at fire exit doors.

There was fire equipment in place and systems to ensure it was regularly serviced and maintained. Fire drills were occurring regularly and residents had detailed personal emergency evacuation plans in place. However, inspectors found some inconsistencies in residents' documents in relation to the supports they required to safely evacuate the centre. For example, one residents' plan stated that they required the full assistance of one staff in one section and two staff in another. It stated they required the assistance of equipment to evacuate in another section but it was unclear how many staff were required to support them to use this equipment

and evacuate safely.

In addition, in one of the houses the provider had identified a suitable time for residents to safely evacuate in the event of an emergency. They had completed a number of drills and in the months preceding the inspection were unable to evacuate the centre in that timeframe they had identified as suitable. This house was single staffed at times and all six residents were identified as requiring some form of staff support to safely evacuate the house in the event of an emergency. From the documentation reviewed, and speaking with staff it was unclear where the staff would be coming from to support residents to evacuate. The inspectors acknowledge that the provider outlined a number of responsive steps in relation to fire safety in their urgent action plan response following the inspection. This included the action they had, or planned to take to mitigate the risks associated with the fire safety systems and documentation in the centre.

Judgment: Not 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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for A2 OSV-0005387

Inspection ID: MON-0039224

Date of inspection: 15/02/2023

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The two most dependent residents have transferred to a centre that is equipped to support their needs. Following this a review of the required staffing levels will be completed. . Staff from the relief team are being identified to fill vacancies in the centre, this is to ensures consistency of care and familiarity for the residents in Centre A2. Following a recruitment drive on the 21st of March 2023 there have been successful candidates identified who are now engaged in compliance checks in advance of commencement of employment. There are ongoing recruitment measures in place to address the current vacancies.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The PIC and CNM 1 will review all care planning documentation to address gaps identified during the inspection, this will ensure that the information is consistent throughout the care plan. The Fire Safety documents including the PEEP have been reviewed and updated. Money Management and Financial passports will be reviewed to ensure consistency and accuracy. Residents assessed need will be reviewed to include the behavioral support needs of the residents. The PIC will audit care plans monthly with a report and action plan furnished by the PIC to the assistant director of nursing and social care. The PIC is reviewing the induction documentation to ensure it reflects the most up to date information regarding the care and support needs of the residents and that it reflects the information in the residents' personal plan, this is to support relief, agency,	

and new staff to become familiar with the resident's needs.
The PIC will complete monthly reviews of the care plan and induction documentation to ensure the most up to date and accurate information is available.
The ADON will ensure that the PIC has a robust induction process in place and that it is used and reviewed consistently.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The schedule for the 6 month and annual reviews has been revised to ensure the turnaround and submission of the reports are completed within a timely manner. The schedule for the June 2023 reports will reflect the revised submission dates. Education and feedback have been provided to the review team to ensure that the importance of the residents input is reflected in the review process. Following a recruitment drive on the 21st of March 2023 there have been successful candidates identified who are now engaged in compliance checks in advance of commencement of employment. Staff from the relief team are being identified to fill vacancies in the centre, this is to ensures consistency of care and familiarity for the residents in Centre A2

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 review of the skill mix of the centre will take place to ensure that that the social care needs of the residents are met, that residents are supported to engage in community activities of their choice, and this is reflected in their personal plans. The PIC will provide guidance and support to staff with documenting meaningful activities and supporting residents with setting goals and achieving these goals. As part of the monthly care plan audit the PIC will ensure there is evidence of resident engagement in meaningful activities and goal setting. The PIC will provide the assistant director of nursing and social care a monthly meaningful activities planner to show planned goals for the weeks and months ahead. Residents will be supported with monthly key worker meetings in planning goals and facilitating residents to feedback from goals achieved.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Two residents recently moved to more suitable accommodation due to their assessed dependency levels, this has reduced the amount of equipment requiring storage in the Centre.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Inconsistencies in the information contained in the care plan including the PEEP, Fire evacuation risk assessment, Maintaining My Independence and safety document, Moving and Handling risk assessment and fire evacuation plan have been addressed. A detailed memo was issued outlining the process to follow in the event of a fire to ensure that there is no ambiguity among staff. The Memo identifies where support will come from to assist with evacuation. Two residents who had been assessed as having high dependency needs have moved from Centre A2 to more suitable accommodation, this has reduced the dependency levels within the centre. Further fire drills in the centre are planned for April 2023 to ensure all staff are aware of the evacuation process.	

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)(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	31/05/2023
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/05/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	31/05/2023

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
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.	Not Compliant	Orange	31/05/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/05/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/05/2023
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.	Not Compliant	Orange	30/04/2023
Regulation	The registered	Not Compliant	Orange	31/05/2023

23(1)(a)	provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	31/05/2023
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Not Compliant	Orange	31/05/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and	Substantially Compliant	Yellow	30/06/2023

	shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	20/02/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	17/02/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	20/02/2023