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:	The Willows
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	15 December 2021
Centre ID:	OSV-0002394
Fieldwork ID:	MON-0034683

About the designated centre

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

The Willows is a designated centre operated by St Michael's House located in a suburban area in Dublin city. It provides community residential services to seven residents, both male and female, over the age of 18. The designated centre is a two storey house and adjoining apartment. The house accommodates six people and consists of a sitting room, kitchen/dining area, quiet room, a staff sleep over room or office, a bathroom and six individual bedrooms (four of which are en-suite). The apartment accommodates one person and consists of two bedrooms (one of which is en-suite), bathroom and kitchen/living room. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge, nurses and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 December 2021	09:40hrs to 14:45hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced risk inspection. It was scheduled to inspect against the provider's compliance plan which was received subsequent to an inspection in the designated centre on 05 October 2021. High levels of non-compliance were identified on that inspection and the provider was required to submit a compliance plan detailing measures to be taken in order to address failings. This inspection was therefore scheduled in order to review the progress that the provider was making in coming in to compliance with the Health Act 2007 (as amended) and associated regulations.

The inspector had the opportunity to meet with all residents on the day of inspection and to view all parts of the designated centre including the adjoining apartment. The inspector greeted all residents and some chose to interact with the inspector while others chose to continue with their daily routine. The inspector wore a face mask, maintained physical distancing and followed good hand hygiene procedures during all interactions with residents and staff. The inspector used observations, conversations with residents and staff, as well as a review of documentation to form a judgment on the quality and safety of the service that the residents were receiving.

The inspector observed that residents appeared relaxed in their home. Some residents were engaged in sensory activities in their bedrooms or were listening to music when the inspector arrived. Other residents were still asleep as was their preference. The atmosphere in the centre appeared relaxed and comfortable. The inspector met with one resident who lived in the apartment adjoining the house. This resident greeted the inspector and showed her around their home. The staff working with the resident appeared to know them well and engaged in conversation about their plans for the day and their Christmas decorations.

There were activities for the day on the activities notice board which included colouring and going out for coffee. The person in charge stated that they were currently reviewing the activities board and showed the inspector pictures which they had created to support residents in making choices and understanding the routines for the day. Some residents were observed leaving the centre throughout the course of the day to go for walks in the community.

The inspector saw that the provider had made progress towards achieving some of the actions identified in the previous inspection including replacing fire doors and fixing self-closing mechanisms. Other actions remained outstanding including painting. Equipment for residents' use which had previously been stored in the hall was stored under the stairs or in the bathroom on the day of inspection. This contributed to a more homely feel in the centre. The centre was clean and generally tidy. Staff were observed supporting residents in a gentle and relaxed manner.

Capacity and capability

The inspection was an unannounced inspection, the purpose of which was to monitor progress the provider was making in coming into compliance following non-compliances identified at the previous inspection on 05 October 2021. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service and how effective it was in ensuring that a good quality and safe service was being provided.

The inspector found that the provider was in the process of implementing the measures, as set out in their compliance plan response, to enhance the oversight of the designated centre. The person in charge had access to dedicated management hours which were detailed on the roster. Regular management meetings were held which involved the person in charge, service manager and senior management. Minutes of those meetings were kept. A review of the minutes showed that clear actions which were specific, measurable and time bound were set in order to address issues identified at meetings. There was evidence that the centre's service improvement plan was being used as an active document to continuously drive service improvement. The inspector also saw that information was provided to staff in the designated centre about their roles and responsibilities in the day to day running of the centre through regular staff meetings.

The provider was continuing to attempt to fill staff vacancies. The inspector was informed that two whole time equivalent staff had recently been recruited and were scheduled to commence employment in the designated centre in early January 2022. There remained a high reliance on relief and agency staff in the designated centre in order to complete the roster in the interim. The person in charge had enhanced the measures in place to ensure that all relief and agency staff were fully inducted and were aware of the procedures and policies for the designated centre. A local induction folder was available for all new and relief staff which provided details on emergency contacts, the house evacuation plan and a checklist for completion with staff before commencing their shift. The inspector saw evidence that this checklist had been completed for recent agency staff who had worked in the centre.

A staff training matrix was reviewed by the inspector on the day of inspection. This demonstrated that the majority of deficits previously identified in the area of staff training and supervision had been addressed by the provider. At the time of inspection, all staff had completed mandatory training in key areas such as fire safety, safeguarding, COVID-19 and feeding, eating, drinking and swallowing. There were some gaps in trainings which were required to be delivered face to face however the inspector was informed that dates had been secured for this training and would be completed in the coming weeks. A staff supervision schedule had been implemented and all staff had received supervision subsequent to the last

inspection. Dates were set out for further supervision meetings in the coming weeks. The person in charge also had access to regular supervision meetings with the service manager.

Finally, the provider had ensured that all staff were aware of where to locate the Schedule 5 policies. A list of Schedule 5 policies was available with details of where to find these online in the local induction folder.

Regulation 15: Staffing

There continued to be several staff vacancies in the designated centre with a high reliance on agency and relief staff to complete the roster. The person in charge had enhanced the measures in place to ensure that all relief and agency staff were inducted before commencing their first shift on-duty. The inspector was informed that two whole time equivalent staff had recently been recruited and were scheduled to commence employment in early January 2022.

A planned and actual roster was maintained for the centre

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training matrix was maintained in the designated centre. It was clear on review of this matrix, that the provider had made significant progress in coming into compliance in the area of staff training and development. All staff were up-to-date in several key training areas. Small numbers of staff required face to face training in areas such as first aid, safe administration of medication and epilepsy. The inspector was informed that dates were secured for these and that training was scheduled to take place in the coming weeks. The staff training which was required included:

- managing behaviour that is challenging: 25% of staff required this
- first aid: 33% of staff required this
- Therapeutic Intervention Principles (TIPS): 21% staff required this
- Evacuation bed: 40% staff required this
- Safe Administration of Medications (SAMS): 10% of staff required this
- epilepsy: 10% of staff required this

There were also enhanced supervision arrangements for staff with all staff having received supervision within the last quarter. A schedule of supervision meetings for the next quarter was also established. The person in charge had enhanced the arrangements to ensure that agency and relief staff were inducted to the designated

centre and were aware of the policies and procedures to be followed.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had taken measures to enhance the governance and management arrangements of the designated centre. There was a clear management structure with lines of accountability identified. There was evidence that the provider was using the service improvement plan as a working document to drive ongoing service improvements. The service improvement plan was regularly updated in order to track progress towards full compliance. Monthly data reports were also completed which enhanced the oversight of the running of the centre.

There were several actions of the provider's compliance plan which remained in progress at the time of inspection. These included premises works, staffing and face to face staff training.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The person in charge had removed out-of-date Schedule 5 policies and had implemented a new folder which provided instructions on how to locate the provider's policies on the provider's intranet. This ensured that staff had access to the most up-to-date versions of policies.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. The inspector observed that the provider was implementing measures in order to come into compliance since the last inspection. The provider had submitted a comprehensive compliance plan and service improvement plan for the centre. These plans set out clear actions for the centre which were time-bound and allocated to responsible individuals. There was evidence on the day of inspection that the provider had met some of their targets on these plans and was on track to achieve other targets.

The provider had completed comprehensive audits in the area of infection prevention control and had significantly enhanced the measures to address risks identified in the area of fire containment and evacuation. The inspector was not assured however of the measures in place to ensure that all residents could be safely evacuated in the event of a fire occurring at night time. An urgent action was issued on the day of inspection and the provider was required to submit an urgent compliance plan response detailing how they had addressed this risk.

The provider had enhanced the measures to contain fire by installing new fire doors in the utility and bathroom and repairing self-closing mechanisms which previously had not been functioning adequately. All staff had completed fire safety training at the time of inspection. Day and night time drills had been completed and the person in charge had documented evidence of fire walk-through drills which were completed with relief and agency staff. A fire prevention plan for the designated centre had been recently reviewed.

The review of the fire drills by night identified several issues. Firstly, the average time frame for all residents to be evacuated safely by night was lengthy. Additionally, the fire drills identified a risk whereby a resident re-entered the centre during the evacuation. An urgent action was issued and the provider was required to provide assurances that they were satisfied that the night time evacuation arrangements were sufficient. The provider set out in their urgent compliance plan response that they had reviewed the evacuation arrangements with a competent fire person and were satisfied that the fire containment measures would afford sufficient time to evacuate all residents. The provider also stated that they were assured that the incident whereby the resident re-entered the building was a once-off occurrence and committed to continuing to monitor this and respond accordingly should a trend appear. The provider committed through their urgent compliance plan response to take measures to complete premises works which would allow for a faster evacuation time by end of March 2022.

The inspector saw that the designated centre was clean and tidy. A comprehensive hygiene audit was completed which identified robust, specific and measurable actions. There was evidence that the provider had addressed some of these actions by the time of inspection and was in process of addressing others. A COVID-19 folder was available to staff. This folder contained an updated COVID-19 contingency assessment and plan which was comprehensive and detailed specific measures to be taken in the even of a suspected or confirmed case of COVID-19 in the designated centre.

The premises required maintenance throughout. There were several issues which remained outstanding from the previous inspection and additional premises issues were identified in the apartment, which was not visually inspected on the last inspection. Some of these issues presented a risk to infection prevention and control and were documented on the provider's hygiene audit. For example, the woodwork around the bath in the apartment was observed to be flaking and peeling and therefore could not be adequately cleaned. The provider's hygiene audit put environmental compliance at 64%. Many of these issues had been logged as

maintenance requests but remained outstanding.

The inspector saw that resident bedrooms were equipped with furniture and furnishings as per residents' assessed needs and individual preferences. However, improvements were required to the procedures in place to support residents to manage and store their personal property. The inspector saw that one resident did not have a wardrobe and was storing clothes on a clothes rail. Another resident had recently been supported to clear out old belongings from their room. However, these belongings were being stored in the resident's en-suite shower while awaiting removal. The resident was reported to not use the bathroom independently, preferring to use the larger, accessible bathroom. However, the storage of belongings in the shower contributed to a cluttered and unhygienic environment. Two residents had their wardrobes and drawers labelled to show where their clothes should go. This was not done so in a manner to support residents with independent dressing, they were labelled by a staff member to make it more efficient for their needs. There was no evidence that this was done in consultation with residents or as per their preferences.

The centre's risk register had been recently reviewed and was found to be an accurate reflection of the risks presenting. Individual risk assessments were available as required.

A review of resident files demonstrated that a comprehensive assessment of need was available on file for residents. The assessment of need was used to inform care plans for residents' assessed needs. Care plans were written in a person-centred manner and provided clear guidance for staff on how they should provide support to residents which was respectful of residents' dignity and autonomy. It was evident that residents had access to a variety of health care professionals as required including speech and language therapy, physiotherapy and occupational therapy. Support plans were supported by relevant clinical guidelines where required.

It was evident that residents had access to primary and secondary health care services as required. Where residents had refused treatment to interventions, this was clearly documented, respected and brought to the attention of the medical practitioner. There were support plans in place which documented how residents who communicated non-verbally may demonstrate that they did not consent to medical interventions. These support plans detailed how staff should listen, respond and respect residents' choices if they are not consenting to interventions.

Positive behaviour support plans were available on resident files where required. There was evidence that these had been recently reviewed and that staff had signed off on having read them within the last 12 months. Behaviour support plans were written in person-centred language and detailed proactive and reactive strategies to support staff in managing behaviour that is challenging. Restrictive practices had been reviewed by the provider's positive approaches to monitoring group (PAMG). The necessity for some restrictive practices were further supported by relevant clinical guidelines.

The provider had taken measures to protect residents from abuse. There were up-

to-date policies and procedures available in relation to safeguarding. All staff had completed safeguarding training. Intimate care plans were available on resident files. These were written in person-centre language and provided clear steps for staff to support residents in a way that respected resident's dignity, autonomy and was mindful of individual preferences. Intimate care plans set out how staff can ensure that residents who communicate non-verbally can make choices and retain control during the provision of intimate care.

The inspector saw that the centre provided a relaxed and comfortable atmosphere to residents and that activities and choices were offered in line with residents' preferences and needs. For example, some residents chose to sleep in in the morning while other residents chose to go for a walk in the community. A review of the roster and the house weekly planner of activities showed that residents had access to a variety of in-house and community based opportunities for occupation and recreation. In-house activities included listening to music, art, trampoline or sensory activities. Residents also had access to community based activities including going for a walk, to the cinema or visiting family. Residents were planning for a in-house Christmas celebration the following week and had engaged in community based Christmas activities recently including Wild Lights and Wonderlights. The person in charge was in the process of adapting the daily schedule for the house to enhance it's accessibility and to support residents to make choices.

Regulation 12: Personal possessions

Some residents did not have adequate storage to store their clothes and belongings in a safe and hygienic manner. Other residents had their wardrobes and drawers labelled to show where their clothes should be stored. This was not done in line with resident preferences or to support them in independent dressing but was done by staff for their own efficiency. This did not contribute to a homely or personalised atmosphere in resident bedrooms.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents had access to facilities for occupation and recreation in line with their assessed needs and their wishes. Residents were also supported to access their community and to maintain links with their family and loved ones. There was evidence of a variety of in-house and community based activities which were offered to residents in a person-centred manner.

Judgment: Compliant

Regulation 17: Premises

The premises continued to require maintenance and upkeep. These issues had been captured on the provider's hygiene audit and compliance plan response. There was evidence that these issues were logged with maintenance departments. The provider had committed to addressing these some of issues in their service improvement plan by 30 March 2022.

The premises issues identified included:

- paint flaking around the bathtub in the apartment
- water marks through the paint on the walls of apartment bathroom
- wall damaged around the sitting room door in the apartment
- bedroom 3 main house: paint chipped on bed and dresser
- bedroom 4: water stains on ceiling
- kitchen, main house: water stains on ceiling

Judgment: Not compliant

Regulation 26: Risk management procedures

There was an up-to-date risk management policy available to staff. The centre's risk register was reviewed and was found to be an accurate reflection of the known risks in the designated centre. Individual risk assessments were available for each risk and had recently been reviewed and updated

Judgment: Compliant

Regulation 27: Protection against infection

The designated centre was observed to be clean and tidy. A comprehensive hygiene audit was completed which identified several actions. There was evidence that the provider was using the hygiene audit in order to drive service improvement and had already taken action to address some of the risks identified. Other hygiene risks remained outstanding however these have been captured under premises issues and had been logged with the provider's maintenance department as such.

Staff were seen to adhere to standard precautions and to encourage good hand hygiene with residents. A COVID-19 folder was available for the designated centre.

This folder set out procedures to be followed in the event of a suspected or confirmed outbreak fo COVID-19 and provided clear advice to staff which was in line with current public health guidance.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had taken measures to significantly enhance the fire safety management systems in the designated centre. All staff had received fire safety training. Fire doors which were not working correctly had been replaced and self-closing mechanisms had been adjusted. There was evidence that regular day and night time fire drills were completed. The registered provider was required to provide assurances that there were sufficient mechanism in place to ensure that all residents could be safely evacuated at night time in a suitable time frame. The provider was satisfied that the night time fire arrangements were sufficient and set out that they planned premises works to be completed by 30 March 2022 which would further reduce the evacuation time.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A review of several resident files demonstrated that residents had a comprehensive assessment of need which had recently been updated. Care plans were available for each assessed need. Care plans were written in person-centred language and were further supported by relevant clinical guidelines as required. Care plans were multidisciplinary, involved consultation with the resident and were developed through a person-centred approach.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a variety of primary and secondary health care specialists as per their assessed needs. A review of resident files demonstrated that residents had access to general practitioners, hospital consultants and allied health care professionals as required. Resident care plans supported residents' right to refuse medical interventions and provided detail to staff on how residents who

communicated non-verbally may consent or not.

Judgment: Compliant

Regulation 7: Positive behavioural support

The majority of staff had received training in managing behaviour that is challenging at the time of inspection. A small number of staff were awaiting in-person training. The inspector was informed that this had been booked for the coming weeks.

Up-to-date positive behaviour support plans were available on resident files which reflected best practice and provided clear guidance to staff on how to support residents.

Restrictive practices had been notified to the Chief Inspector and reviewed by the provider's positive approaches to monitoring committee (PAMG). Clinical guidelines and recommendations were available to enhance oversight of some restrictive practices.

Judgment: Compliant

Regulation 8: Protection

The provider had taken measures to protect residents from abuse. There were safeguarding measures in place to ensure that staff providing intimate care to residents did so in a manner which was in line with residents' personal plan and respected their right to dignity and bodily integrity. All staff had completed training in safeguarding and Children First.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Willows OSV-0002394

Inspection ID: MON-0034683

Date of inspection: 15/12/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The registered provider continues to interview to fill current vacancies. Staff Nurse and Direct Support worker vacancies completed recruitment process and in place in the centre since Jan 2022. The registered provider will continue to source experienced staff to fill vacancies within the designated centre. Ensuring that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre • PIC and PPIM continues to complete the roster in a timely manner including regular relief to cover any gaps left by vacancies to ensure a consistent service is provided for all residents in The Willows. The PIC and PPIM will complete on working actual roster to demonstrate the shifts covered at that time. • The PIC has implemented measures that ensure that all relief and agency staff were inducted before commencing their first shift on-duty	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge will continue to ensure that staff have access to appropriate training, including refresher training, as part of continuous professional development programme. Mandatory training is scheduled and planned within the working roster. • The PIC has devised a priority list of training for staff team in The Willows and schedule	

for completion in line with training department guidance and current government and HSE guidance
The PIC will continue to liaise with the training department to ensure all staffs training needs are met within the dates outlined going forward.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• In response to non compliance under regulation 23 (1) (a) The Person in Charge will continue to ensure that staff have access to appropriate training, including refresher training, as part of continuous professional development programme. Mandatory training is scheduled and planned within the working roster.

• In response to non compliance under regulation 23 (1) (a) The registered provider continues to interview to fill current vacancies. Staff Nurse and Direct Support worker vacancies completed recruitment process and in place in the centre since Jan 2022. The registered provider will continue to source experienced staff to fill vacancies within the designated centre. Ensuring that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre

• In response to regulation 17 (1)(b) The Register Provider has a schedule of work for the designated centre to ensure that the premises are in a good state of repair

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
In response to Regulation 12 (3) (d):

• The person in Charge has assisted resident to purchase storage in order to maintain clothing and personal property in a safe and hygienic manner.

• The Person in Charge and PPIM have removed labels from storage units within the designated centre

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • In response to regulation 17 (1)(b) The Register Provider has a schedule of work for the designated centre to ensure that the premises are in a good state of repair and all identify areas from the inspection will be completed within the agreed timeframe.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • In response to regulation 27 The Register Provider has a schedule of work for the designated centre to ensure that the premises are in a good state of repair in order to enhance protection of residents at risk of a healthcare associated infection	

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 12(3)(b)	The person in charge shall ensure that each resident is supported to manage his or her laundry in accordance with his or her needs and wishes.	Substantially Compliant	Yellow	01/02/2022
Regulation 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Substantially Compliant	Yellow	01/02/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the	Substantially Compliant	Yellow	31/05/2022

	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.	Substantially Compliant	Yellow	31/05/2022
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	01/04/2022
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	30/03/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/03/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Substantially Compliant	Yellow	31/05/2022

	is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.			
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.	Substantially Compliant	Yellow	30/03/2022