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:	Mullingar Centre 1
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	12 January 2022
Centre ID:	OSV-0004090
Fieldwork ID:	MON-0030827

About the designated centre

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

Mullingar Centre 1 supports eight individuals with moderate to severe intellectual disability and specific support needs in relation to health care, behaviours of concern and autism. The service is offered to both male and female adults and is a 24 hour service. The provider aims to provide people with an intellectual disability and their families a service which promotes each resident's best interests, choices and that optimally captures the balance of empowerment and necessary safeguards. The designated centre comprises of two community houses in close proximity to the local town. Each resident has their own bedroom, as well as access to the communal areas and garden areas. The residents are supported by both social care and nursing staff as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 12 January 2022	10:15hrs to 18:15hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, from what the inspector observed, residents received appropriate care and support in the centre. However, there were improvements required in relation to the statement of purpose, training and staff development, premises, risk management, protection against infection and fire precautions. These issues are discussed further in the next two sections of the report.

This centre was made up of two houses with four residents living in house one and two residents living in house two. The inspector had the opportunity to meet with all six of the residents. Residents with alternative communication methods, did not share their views with the inspector, and were observed throughout the course of the inspection in their home.

Staff were observed to communicate with the residents in house one using a mixture of verbal language and gestures. In this house residents were observed relaxing in the kitchen interacting with staff or being supported to have their lunch, while others listened to music or watched movies. There was a "Share a Break" scheme operating in this centre which was managed by the social work department within the organisation, this meant that specific volunteers provided some external activities and social outlets for some of the residents. On the day of the inspection one of the resident's went out for a long walk with their link person from this scheme. This link had been long standing for the resident and took place weekly.

Other residents in the house went out for walks or drives at different times of the day. Some residents had one-to-one sensory sessions with staff in the centre's new sensory cabin in the back garden. The inspector was invited to view this cabin which was observed to be well equipped with sensory items, different choices of seating and a projector for meditation, relaxation sessions or a home cinema experience. Staff spoken with stated that the sensory cabin was a welcomed addition to the centre and residents had benefited from its use.

One of the resident's spoke to the inspector and stated that they liked the house and that they were involved in day to day decisions in their life. They said they felt comfortable telling staff if they wanted to do something or wanted an alternative meal choice. They were observed interacting with a staff member about plans to buy a new smart phone and the resident had looked up options on their current phone. The staff member engaged in conversation about what colour phone the resident might decide to purchase.

In house two, the residents were relaxing in the dining area with staff when the inspector arrived. One of the resident's greeted the inspector at the door and gave the inspector a tour of some of the rooms. The residents appeared relaxed in their home and in staff company. Both residents had been out for a drive and a walk in the morning and that afternoon one resident went for a drive to an allotment garden and helped with the gardening of the vegetables and collected eggs from the

chickens. They also chose to attend some of the feedback meeting at the end of the inspection.

The majority of residents in this centre availed of an in-house day programme. One resident attended an external day service programme Monday to Friday. Residents were supported to participate in different activities in and out of the centre such as walks, drives, massages, going to the library, cinema, making sensory items and art work.

Both houses appeared homely and clean. Some residents from each house had art work displayed in their rooms that they had painted or created. Each resident had their own bedroom that was individually decorated to their personal preferences. There were adequate storage facilities for their personal belongings and there were personal items, pictures and collages displayed in their bedrooms.

House one had a swing in the garden, a sensory cabin and lots of home made colourful sensory items and a picnic bench. There was a painted colourful rock display as dedication to residents that had lived in the centre. There was an apple tree and some vegetable patches that residents helped take care of. House two had a large front and back garden. There was a picnic bench for residents to sit out if there was good weather. The residents in this house had preferred to go to an allotment garden to undertake gardening rather than in their own garden.

There were three staff on duty in house one on the day of inspection and two staff on duty in house two. Staff spoken with were knowledgeable on the residents' care and support needs required. They were observed to provide support in line with residents' personal plans and engagement was found to be responsive and respectful.

As part of the annual review the provider had given residents and their representatives the opportunity to give their thoughts on the service provided to them. Feedback received indicated that people were satisfied with the service and in particular with the staff in the centre.

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

Overall, the inspector found there were management systems in place to ensure good quality care was being delivered to the residents and the centre was adequately resourced. However, some improvements were required in relation to the statement of purpose and training and staff development.

There was a statement of purpose available that was updated regularly. However, it

was not updated in line with the addition of the new sensory cabin in the garden as required by Schedule 1 of 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). No other aspect of this regulation was reviewed at this inspection.

There was a defined management structure in place which included the person in charge who was employed in a full time capacity and had the qualifications and experience to fulfil the role. They appeared familiar with the residents care and support needs. There were support arrangements in place for a deputising person in charge and members of senior management to help with the running of the centre as required. House one also had a long standing staff member in the role of team leader and they were very familiar with the needs and preferences of the residents.

The provider had carried out an annual review of the quality and safety of the centre and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis. The inspector looked at the annual review and the six-monthly visits and found that any actions identified had been followed up on. The annual review of the service had included consultation with residents and family representatives. There were other local audits and reviews conducted within the centre in areas such as finance audits, infection prevention and control and medication audits. Actions identified from the previous Health Information and Quality Authority (HIQA) inspection had been addressed by the time of this inspection.

From a review of the rosters the inspector saw that there was a planned and actual roster in place that accurately reflected the staffing arrangements in the centre and it was maintained by the person in charge. Staff files were not reviewed as part of this inspection however, the inspector did review a sample of Garda vetting forms for agency staff employed within the centre and found they were in place.

Staff had access to necessary training and development opportunities in order to carry out their roles effectively and to meet residents' assessed needs. For example, staff training included, safeguarding of vulnerable adults, medication management, fire safety training, and infection prevention and control trainings. However, it was difficult to ascertain if records were accurate and the most up-to-date. At the time of inspection two staff were due to complete a particular infection prevention and control training. Refresher training was due for two staff with regard to hand hygiene training, two staff were due refresher training in manual handling and two staff were due refresher training in epilepsy and emergency medication training.

There were formalised supervision arrangements in place and staff spoken with said they felt supported and would be comfortable bringing matters of concern to the person in charge if required. There were also monthly staff meetings occurring in the centre.

From a review of incidents that had occurred in the centre since the last inspection, the person in charge had notified the Chief Inspector of Social Services in line with the regulations when every adverse incident had occurred.

Regulation 14: Persons in charge

The person in charge who was employed in a full time capacity and had the qualifications and experience to fulfil the role. They appeared familiar with the residents care and support needs.

Judgment: Compliant

Regulation 15: Staffing

From a review of the rosters the inspector saw that there was a planned and actual roster in place that accurately reflected the staffing arrangements in the centre and it was maintained by the person in charge. Staff files were not reviewed as part of this inspection however the inspector did review a sample of Garda vetting forms for agency staff employed within the centre and found them to be in place.

Judgment: Compliant

Regulation 16: Training and staff development

There were formalised supervision arrangements in place and staff spoken with said they felt supported and would be comfortable bringing matters of concern to the person in charge if required. While staff did have access to training opportunities relevant to their job it was difficult to ascertain if records were accurate and the most up-to-date.

At the time of inspection two staff were due to complete a particular infection prevention and control training. Refresher training was due for two staff with regard to hand hygiene training, two staff were due refresher training in manual handling and two staff were due refresher training in epilepsy and emergency medication training.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a defined management structure in place and the centre was adequately resourced. The provider had carried out an annual review of the quality and safety

of the centre and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis. From a review of the the annual review and the six-monthly visits any actions identified had been followed up on. The annual review of the service had included consultation with residents and family representatives. There were other local audits and reviews conducted within the centre in areas such as finance audits, infection prevention and control and medication audits. Actions identified from the previous Health Information and Quality Authority inspection had been addressed by the time of this inspection.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose available that was updated regularly. However, it was not updated in line with the addition of the new sensory cabin in the garden as required by Schedule 1 of 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). No other aspect of this regulation was reviewed at this inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre since the last inspection, the person in charge had notified the Chief Inspector of Social Services in line with the regulations when every adverse incident had occurred in the centre.

Judgment: Compliant

Quality and safety

Overall, residents were receiving good quality, safe care and supports that were individualised and focused on their needs. However, some improvements were required in relation to premises, risk management, protection against infection and fire precautions.

There were arrangements in place to assess residents needs and review the efficacy of the support plans in place with input from allied healthcare professionals as appropriate. There were personal plans in place for any identified needs and these

included plans to support residents with specific health care needs and their communication. Residents were supported by staff to set goals for themselves and some goals viewed had already been achieved or due to happen soon for some residents.

Residents' health care needs were seen to be assessed and appropriate healthcare was made available to each resident. Residents had access to a range of allied health professionals which included a general practitioner (G.P), dentist, speech and language therapist, chiropody, neurology and physiotherapy as required.

Behaviours of concern were not a feature of this service at the time of the inspection. Nonetheless, the residents' emotional wellbeing was supported by staff and clinical input was in place as required. While there were restrictive practices in place, these were assessed as clinically necessary for residents' safety, were subject to regular review and consent had been sought from family representatives. For example, restrictions in place included lap belts on wheelchairs and bed rails.

There were arrangements in place to protect residents from the risk of abuse. There was a safeguarding policy and staff were appropriately trained. There were systems in place to safeguard residents' finances whereby staff counted and signed off on the finances once daily and a finance audit was completed every second month. Residents had intimate care plans to guide staff on how best to support them and inform staff of their preferences.

The inspector found that there were adequate systems in place to promote residents' rights. These included, weekly house meetings and a choice board was in place in the kitchen.

From a walkabout of the centre the inspector found the houses to be spacious and they were designed and laid out to meet the needs of the residents. There were some areas that required attention, for example, both houses required areas to be repainted and in house two some new storage and flooring was required. These identified works had been self-identified by the person in charge and funding applied for however, on the day of inspection no date for these works to be completed had been set.

Risk management arrangements ensured that risks were identified, monitored and for the most part regularly reviewed. The inspector observed that all three vehicles were insured and had an up-to-date national car test (NCT). There was a policy on risk management available and the centre had a recently reviewed risk register in place. Each resident had a number of individual risk assessments so as to support their overall safety and wellbeing. However, a number of COVID-19 risk assessments had not been reviewed within the last year which meant the most accurate information may not be recorded and accounted for. In house one the inspector was not assured that the provider had appropriately risk assessed the new sensory cabin in relation to fire safety management systems. In house two there was a potential trip hazard as the floor was a different level coming from the hall into the second sitting room and this had not been identified on any of the provider's audits and may cause a trip hazard for residents.

The inspector reviewed arrangements in relation to infection control management in the centre. 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, with a contingency plan in place and isolation facilities for residents if required. Staff had been provided with several relevant infection prevention and control trainings. Personal protective equipment (PPE) was available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff at all times due to social distancing not being possible to maintain in the centre. There were adequate hand-washing facilities and hand sanitising gels available throughout the centre. However, improvement was required in relation to the centre's cleaning schedule of equipment used to support residents in house one. The inspector found a significant number of gaps in this documentation and the jacuzzi bath seat used by all residents in this house was found to have powder residue stains on it which would indicate the seat had not been cleaned following use. Slight mould was observed on the wall of one resident's bedroom and around the window of the staff office.

There were fire safety management systems in place, including detection and alert systems, emergency lighting and fire-fighting equipment, each of which were regularly serviced. Staff had received training in fire safety and there were fire evacuation plans in place for residents. However, in house two, two fire doors to residents bedrooms were propped open by the use of a chair. The inspector discussed this with the person in charge however, this had not been rectified by the end of the inspection as these doors were still propped open. Therefore, it was not demonstrated that appropriate fire containment measures were in place in order to provide appropriate protection in the event of a fire.

Also in this house two fire containment doors did not close fully by themselves. This was required to ensure residents were protected from the spread of fire and smoke in the event of a fire. Post inspection the fire doors were adjusted to ensure they closed. Assurances were provided by the provider's fire safety expert that they had examined the doors in both houses and were satisfied that they met requirements and were now closing properly.

Regulation 17: Premises

From a walkabout of the centre the inspector found the houses to be spacious and were designed and laid out to meet the needs of the residents. There were some areas that required attention, for example, both houses required areas to be repainted as had some scuffed paintwork. In house two new storage was required in a spare bedroom, flooring needed replacement in the hall and another spare bedroom due to an old leak. These identified works had been self-identified by the person in charge and funding applied for however on the day of inspection no date for these works to be completed had been set.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A number of COVID-19 risk assessments had not been reviewed within the last year which meant that the most accurate information may not be recorded and accounted for. In house one the inspector was not assured that the provider had appropriately risk assessed the new sensory cabin in relation to fire safety management systems. In house two there was a potential trip hazard as the floor was a different level coming from the hall into the second sitting room and this had not been identified on any of the provider's audits.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While 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 improvement was required in relation to the centre's cleaning schedule of equipment used to support residents in house one. The inspector found lots of gaps in this documentation and the jacuzzi bath seat used by all residents in this house was found to have powder residue stains on it. Slight mould was observed on the wall of one resident's bedroom and around the window of the staff office.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While there were fire safety management systems in place in house two, two fire doors were propped open by the use of a chair. The inspector discussed this with the person in charge during the inspection however, this matter had not been addressed at the end of the inspection as these doors were still propped open. Therefore, it was not demonstrated that appropriate fire containment measures were in place in order to provide appropriate protection in the event of a fire.

Some fire doors had not closed fully by themselves on the day of inspection however, post inspection these were adjusted to ensure they closed and assurances were provided to the inspector.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There were arrangements in place to assess residents needs and review the efficacy of the support plans in place with input from allied healthcare professionals as appropriate. There were personal plans in place for any identified needs and these included plans to support residents with specific health care needs and their communication. Residents were supported by staff to set goals for themselves and some goals viewed had already been achieved or due to happen soon for some residents.

Judgment: Compliant

Regulation 6: Health care

Residents' health care needs were seen to be assessed and appropriate healthcare was made available to each resident. Residents had access to a range of allied health professionals which included a general practitioner (G.P), dentist, speech and language therapist, chiropody, neurology and physiotherapy as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' emotional wellbeing was supported by staff and clinical input was in place as required. While there were restrictive practices in place, these were assessed as clinically necessary for residents' safety, were subject to regular review and consent had been sought from family representatives. For example, restrictions in place included lap belts on wheelchairs and bed rails.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. There was a safeguarding policy and staff were appropriately trained. There were systems in place to safeguard residents' finances whereby staff counted and signed off on the finances once daily and a finance audit was completed every second month. Residents had intimate care plans to guide staff on how best to support them and

inform staff of their preferences.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that there were adequate systems in place to promote residents' rights. These included, weekly house meetings and a choice board was in place in the kitchen.

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	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially 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	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Mullingar Centre 1 OSV-0004090

Inspection ID: MON-0030827

Date of inspection: 12/01/2022

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: The PIC will ensure that staff have access to training required for their role. The PIC has completed a review of the training records to address any outstanding training required. The training records have been updated onto a new format to provide accessible training record at all times. Outstanding for hand hyigene and infection prevention and control training identified during the inspection was completed by staff before the 8th Febuary 2022. Refresher manual handling training has been secheduled for the 14th Febuary 2022 with practical piece to be completed before the 5th March 2022. Training for emergency medication training and epilepsy has been scheduled and will be completed by the 11th March 2022. All actions will be completed by the 11th March 2022.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: A statement of purpose was updated and submitted on the 21st January 22 to incorporate the addition of the new sensory cabin in the garden as required by Schedule 1 of 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).	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The following works have been completed to the designated center. 1. 5 bedrooms were redecorated in both premises to enhance the designated center. Additional insulation works was completed to one bedroom to address the presence of mould. These works were completed by the 4th February 22.	

2. Storage was replaced and fitted by the 21st January 22 in the spare bedroom in house 2.
3. Flooring in house 2 for hall and spare bedroom was measured and ordered on the 17th January 22. Fitting of flooring to be completed by 18th February 22.
4. Outstanding painting of living kitchen dining area and spare bedroom in premises 2 will be completed by the 30th April 2022.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A review of the COVID-19 risk assessments has been completed. The PIC will ensure that risk management plans will be reviewed regularly and will reflect the most up to date information. The Fire Safety Officer visited the site on the 14th January 22 to review the fire safety management system of the sensory cabin in the garden. An external fire company engineer will complete a site visit to survey and review the fire safety management system of the sensory cabin on the 10th February 22. Recommendations will be acted upon receipt of the report. A review of each resident's personal emergency evacuation plans have been completed to include detail supporting residents evacuating from the sensory cabin in the event of a fire. A risk management plan has been developed in relation to the potential trip hazard identified in house 2. The Occupational therapist has completed a review of the environment in house 2 on the 17th January 22.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The cleaning schedule for equipment has been reviewed and personalized to each individual's aids and equipment. The PIC will monitor regularly that equipment is clean and ensure that cleaning of aids and equipment is documented in the cleaning schedule. The Muiriosa policy of cleaning and disinfectant will be discussed with the team at the next meeting. This will be completed by 28th February 22. Insulation works was completed in one bedroom to try to resolve mould present. Cleaning schedule has been revised to include cleaning of mould to ensure that it is dealt with in a timely manner. This work was completed by 4th February 22.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Following completion of inspection, the PIC visited both locations on the evening of the 12th January 22 to un-prop doors which were propped to ensure the fire containment measures in place to provide protection were effective. The PIC advised staff of the danger of such practice. This will be re iterated in the team meeting. Action to be completed by 10th February 22. All fire doors were reviewed and adjusted on the 13th January 22. On the 14th January 22 the Fire Safety Officer completed a site visit to both locations and was assured that they closed properly and were fit for purpose. A review and survey of the sensory cabin fire safety management system on house one will be

completed by a fire company engineer on the 10th February 22.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	11/03/2022
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.	Substantially Compliant	Yellow	30/04/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	04/02/2022
Regulation 26(2)	The registered provider shall	Substantially Compliant	Yellow	10/02/2022

	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.			
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	28/02/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	10/02/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	21/01/2022