Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	Red House
Name of provider:	The Rehab Group
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	24 October 2022
Centre ID:	OSV-0002650
Fieldwork ID:	MON-0033386

About the designated centre

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

Red house is a single storey purpose built facility located outside a main city. Vehicle access is provided to enable children to access local amenities, schools and leisure facilities. There is a playground and a large garden available on the grounds of the centre. The centre provides respite care and support services for up to five children with a diagnosis of autism. The service is provided to both male and female children between the ages of six and 18 years. The service is a regional service covering a number of counties and is funded by the Health Service Executive (HSE). It is open 325 nights each year. The centre also offers an after school and day care service. Children are supported by a staff team which includes care staff, a team leader and the person in charge. Each child is supported by the required number of staff that they are assessed to need.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

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
Monday 24 October 2022	09:30hrs to 17:10hrs	Elaine McKeown	Lead
Monday 24 October 2022	09:30hrs to 17:00hrs	Kerrie O'Halloran	Support

What residents told us and what inspectors observed

This was an unannounced inspection to monitor the provider's compliance with the regulations and to follow up on the provider's progress with actions identified during the previous inspection completed in March 2021. In addition, to ensuring residents were being supported to have a good quality of life in a safe environment while being supported as per their assessed needs.

The inspectors did not get to meet any of the current residents availing of services in this designated centre. One resident had already left the designated centre to attend school before the inspectors arrived. The designated centre was scheduled to close until the day after this inspection. The person in charge outlined the rationale for this planned closure for one night. This included ensuring maintenance could be completed without impacting on residents. The inspectors observed maintenance staff to be present on their arrival to the designated centre. The inspectors met with a number of the core staff team which included the person in charge and team leader. Both of these staff members assisted the inspectors throughout the inspection.

A total of 12 residents were in receipt of regular respite services within the designated centre. During the inspection, the staff team outlined how they supported each individual in line with their assessed needs. This included specific information regarding effective communication with the residents, the management of ongoing medical issues and the preparation required to support residents to transition out of this children's respite service. In addition, the staff team continued to provide respite services and other support services to the residents and their families throughout the pandemic. This designated centre remained open while adhering to public health guidelines. The staff team outlined the benefits which included maintaining regular routines that had been established over long periods of time and were essential for the wellbeing of some of the residents.

The inspectors were informed of known preferences relating to bedrooms and the use of some communal spaces such as the relaxation room. As the residents have grown older, the use of such spaces has evolved. Staff also informed the inspectors of specific risks that had been identified for individual residents and controls that were in place to ensure the residents ongoing safety while in the designated centre. For example, the bed linen provided for one resident could not have any buttons due to the high risk that they may ingest them.

Due to the assessed needs of the current residents a maximum of three residents were supported at a time. When required, an individualised respite service was also provided. Such a service had been provided to one resident for the night prior to this inspection. Additional night staff resources were in place throughout the night as per the resident's assessed needs. In addition, the staff team had commenced their day shift 30 minutes early on the morning of this inspection to facilitate the usual routine for the resident. The inspectors were informed that this resident

attended the respite services two nights each month, with staffing resources managed to support the individualised service provided to the resident.

Staff were observed to complete regular cleaning duties throughout the designated centre during the inspection. Evidence of good infection prevention and control (IPC) practices were evident during the inspection, which included staff being observed to be wearing appropriate personal protective equipment (PPE). The inspectors also adhered to public health guidelines during the inspection and wore the recommended PPE. In addition, staff spoken to outlined the pre-planning undertaken in advance of the scheduled commencement of respite services on the day after this inspection. This included ensuring known food preferences were available for the residents scheduled to attend.

The inspectors conducted a walk around of the designated centre which was found to be well ventilated. Individual bedrooms were brightly painted and there was adequate communal space for the residents to use as per their wishes. Staff outlined the plans in progress regarding the maintenance of the external areas which included the removal of damaged garden furniture and cleaning of the playground and patio surfaces. However, the inspectors observed inconsistencies in the floor plans and the actual layout of the designated centre. Damage was also evident to a number of fire doors. These issues were discussed with the person in charge during the inspection.

In summary, residents were supported to receive respite services in line with their assessed needs. This included individualised support where required or smaller groups attending to ensure the ongoing safety at all times for the residents. However, number of general maintenance issues in addition to those already mentioned in the previous paragraph were identified regarding the premises. These will be further discussed in the quality and safety section of this report

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

Capacity and capability

Overall, the inspectors found that there was a governance and management structure with systems in place which aimed to promote a safe and person-centred service for children availing of respite services in this designated centre. However, the provider was required to complete a further review of the designated centre's floor plans and statement of purpose to ensure these documents accurately reflected the premises.

The person in charge worked full time and had remit over two designated centres located adjacent to each other. They were supported in their role by a team leader

who worked full time in this designated centre. Both staff demonstrated throughout the inspection, knowledge of their roles and responsibilities. In addition, they were familiar with the individual assessed needs of the current residents availing of respite services.

There was a core staff team in place. The provider had recently recruited three new staff. At the time of this inspection there were two vacancies identified by the person in charge. The provider was actively engaged in a recruitment process. While regular agency staff were available to provide support where gaps in resources were identified, the team leader and person in charge ensured a familiar staff was always on duty to ensure consistency in the service provided to the residents. All staff were supported to attend regular supervision with their line manager. In addition, regular staff meetings had taken place to ensure sharing of information and learning between the staff team.

The inspectors were informed that the provider was aware that some residents contracts referenced the previous entity by which the provider was known. The person in charge outlined that all residents contracts were scheduled to be updated by the end of 2022. A number of contracts reviewed by the inspectors had been completed in 2016 and 2018 with a reference documented that these contracts were ongoing.

The registered provider had ensured that an annual review had been completed in 2021. The reflections of family representatives were also included in this review, which were positive and no issues reported with the service provided. Regular communication from the staff team provided assurance to families while their relative was attending for a respite stay. In addition, the auditors ensured that family representatives were aware of how to make a complaint. The responses received reflected that the family representatives were aware of the process but had not had cause to made a complaint.

The inspectors reviewed the floor plans for the designated centre when conducting a walk around. A number of issues were identified which were discussed with the person in charge during the inspection. These included inconsistencies on two different sets of plans regarding the naming of bedrooms. For example, the floor plans in the fire evacuation protocol referred to the bedrooms numerically. This was consistent with floor plans submitted by the provider to the Health Information and Quality Authority (HIQA). However, the floor plans that were on display in the designated centre referred to the bedrooms by different names. This issue was addressed during the inspection. However, none of the floor plans reviewed contained a fire door that was present in the hallway near the entrance to the designated centre. In addition, not all of the room dimensions documented in the statement of purpose accurately reflected the dimensions contained within the floor plans.

While the staff team outlined to the inspectors the process involved regarding the development of personal plans for each resident upon commencement of service provision in the designated centre, this was not clearly documented in statement of purpose. This was discussed with the person in charge and team leader during the

inspection.

Regulation 14: Persons in charge

The registered provider had ensured that a person in charge had been appointed to work full time and held the necessary skills and qualifications to carry out their role.

Judgment: Compliant

Regulation 15: Staffing

There was an actual and planned rota in place which demonstrated the ongoing changes required to maintain safe staffing levels in the designated centre. The provider had successfully recruited new staff to fill some staff vacancies, a number were undergoing the induction process at the time of this inspection. The person in charge and team leader also provided front line support to the residents and staff team.

Judgment: Compliant

Regulation 16: Training and staff development

A training matrix was in place in this designated centre which identified staff training completed to date and planned training during 2022 which included, site specific training in managing behaviours that challenge, safe guarding and infection prevention and control. However, at the time of the inspection fire safety remained outstanding for 40% of the staff team.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The provider had ensured all the information specified in Schedule 3: Information for residents was maintained and available for review during the inspection.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had ensured that the designated centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had ensured the designated centre was resourced to ensure the effective delivery of care and support to residents. The registered provider had also completed an annual review and internal provider led audits. Actions identified during these audits were completed or documented as being progressed. There was also a schedule of audits in place in the designated centre.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider had changed the entity name during 2022, while this was not reflected on all contracts for the provision of services in this designated centre at the time of this inspection, review of all contracts was scheduled to be completed by 31 December 2022.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose which was subject to regular review. It reflected the services and facilities provided at the centre. However, not all of the required information as outlined in Schedule 1 was accurately reflected in the document. The description and layout of the designated centre was not entirely accurate and the time line for the review of personal plans on admission to the designated centre was not outlined.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all notifications were submitted in writing to the Chief Inspector, including quarterly reports and adverse events as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no open complaints in the designated centre. Staff were aware of the provider's complaints policy. The provider had also ensured family representatives were aware of the process. This was reflected in the annual report and most recent internal provider led audit.

Judgment: Compliant

Quality and safety

Overall, residents' well-being and welfare was maintained by a good standard of care and support to provide a person-centred service where each resident's individuality was respected. However, further improvements were required in the areas of general maintenance and fire precautions.

There were a number of issues identified regarding fire doors in the designated centre during this inspection. These included evidence of damage to the bottom of one door, damage to the door frame and incomplete seal being present on another door and what appeared to be an excessive gap between the floor surface and the bottom of a bedroom door. As previously mentioned in this report, the staff team had an external contractor on site on the day of the inspection to carry out some maintenance. The person in charge ensured that this contractor was made aware of the issues. Following the inspection, the person in charge provided written assurance that all of the fire doors within the designated centre would be reviewed by a person competent in fire safety. In addition, the bedroom where there appeared to be an excessive gap between the door and the floor surface would not be used by any resident until the provider received assurances that the door was fit for purpose. The person in charge also informed the inspectors that they had reviewed the fire risk assessment and commenced increased safety checks in the interim period.

It was observed by the inspectors that the designated centre was provided with all

expected fire safety systems including fire extinguishers, a fire alarm and emergency lighting. Such systems were being serviced at regular intervals by external contractors to ensure that they were in proper working order. All residents had personal emergency evacuation plans (PEEPs) which was subject to regular review. Staff had supported 10 of the residents to participate in a fire drill in recent months. However, a minimal staffing fire drill had not been completed in the previous 12 months.

While the inspectors were informed of actions taken in July 2022 when a fire door in the dining room had been damaged, the controls outlined in the risk assessment were not consistently completed. Twice daily fire safety checks were to be completed from the 23 July 2022 when residents were present in the designated centre. However, following a review of the relevant checklist, these safety checks were completed on only one occasion between 21 -28 August 2022, and no checks were completed on other dates which included 2, 13 and 14 August 2022. In addition, the date when the required repairs were completed was not clearly documented. Inspectors were informed the repairs were completed in September 2022 and the door was observed to be intact during this inspection. Following a review of relevant documentation, inspectors noted weekly fire safety checks including emergency lighting and fire alarm were also not consistently documented.

The inspectors were informed of the number of maintenance issues that were due to be addressed by the provider. These issues included replacement to damaged floor surfaces, which had been highlighted by the person in charge since May 2022. New seating and dining room tables had been ordered and staff were awaiting delivery are these items. The outdoor areas had also been identified as requiring review and maintenance. The inspectors observed a garden bench in poor state of repair which was to be removed and some of the timber structures in the playground required repair. However, the inspectors observed some additional maintenance issues which included damage to a rubber seal on a shower enclosure. A number of items had rust evident which included a hand rail in one bathroom which inspectors were informed was no longer required. Rust had also been identified during the providers own internal of audit on a radiator in one of the bedrooms. While the radiator had been recently painted, rust was still evident on the bottom and on the internal grill at the time inspection. Evidence of wear and tear was also observed on the surface of some of the equipment in the sensory room.

The inspectors reviewed four personal plans during the inspection. There was evidence of regular review and inclusion of family representatives and allied health care professionals as required. Plans were noted to be person centred to support each individual. For example, during the personal planning meetings goals had been identified which included community inclusion and assistance with money management.

The residents had ongoing input, where required, from members of the multi-disciplinary team, including a behaviour support specialist. Behaviour support plans that were in place were noted to be subject to regular review and provided clear guidelines to staff. The input from the staff team was also evident in assisting the

development and updating of these plans to ensure residents were supported effectively in a consistent manner. Restrictive practices were also subject to regular review and the frequency of use of some restrictions had been effectively reduced such as locking a kitchen door. Restrictive practices were also only in place when required to support individual residents and were removed when the resident was no longer present in the designated centre.

The registered provider ensured that residents were protected from the risk of healthcare associated infections and that the designated centre complied with current infection prevention guidelines. The provider had procedures and protocols in place to ensure standards of the prevention and control of healthcare associated infections were consistent. The HIQA self-assessment had been completed and was subject to regular reviews. There was a staff member identified as the COVID-19 lead. In addition, the provider ensured external contractors completed monthly checks on water outlets to monitor for the risk of legionnaires disease.

While it was evident that the staff team completed regular cleaning duties, the inspectors noted stale odours in two rooms. In one bedroom and a bathroom. In addition, build –up of dust and debris was evident under the soft mats that were on the floor of the sensory room. Signage on display regarding the use of colour coded cleaning utensils was not reflective of the provider's protocol. The guidance referred to the yellow bucket to be used for washing of floors and the red bucket to be used for washing the mop heads. The team leader addressed this issue during the inspection to ensure the correct information was reflected on the protocol signage on display in the designated centre before the inspection ended. Inspectors also reviewed the providers policies in relation to IPC. Not all staff had documented that they had read the isolation plan, as required by the provider, that was updated in August 2022.

Regulation 10: Communication

The registered provider had ensured that residents were supported to communicate in accordance with their needs and wishes.

Judgment: Compliant

Regulation 12: Personal possessions

The person in charge ensured residents have access to their personal property and possessions during the respite stay.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider ensured residents were provided with appropriate care which supported individual assessed needs, with access provided to recreational, educational facilities and opportunities to develop life skills in preparation for adulthood.

Judgment: Compliant

Regulation 17: Premises

The registered provider had plans in place to address some maintenance issues identified. However, not all areas internally and externally were maintained a good state of repair at the time of this inspection.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The person in charge ensured that each resident was provided with adequate quantities of food and drink, in line with known preferences. Protocols were in place regarding the proper and safe storage of food and these were observed to be adhered to during the inspection.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had ensured residents were provided with a guide outlining the services and facilities provided in the designated centre in an appropriate format.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured that they were systems in place for the assessment, management and ongoing review of risk. However, not all controls identified regarding a fire safety risk were consistently completed as required.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had procedures in place to protect residents from the risk of healthcare associated infections. However, not all staff had evidenced as required by the provider, that they had read the revised isolation plan which was updated in August 2022. In addition, not all IPC signage on display accurately reflected the provider's protocols relating to the use of colour coding cleaning materials. This was addressed during the inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider ensured that there was a system in place for the management of fire and safety, including fire alarms, emergency lighting and PEEPs for the residents that were subject to regular review. However, a review of all fire doors in the designated centre by a person competent in fire safety was required to ensure compliance with relevant fire regulations. A minimal staffing fire drill had not been completed the previous 12 months.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The registered provider had in place a personal plan for each resident that reflected the nature of their assessed needs and the supports required. Consultant with family representatives was evidenced and ongoing

Judgment: Compliant

Regulation 6: Health care

The registered provider ensured that appropriate healthcare was provided to each resident. Family representatives were supported by the staff team where required to access allied healthcare professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff were aware of residents' behaviour support plans, which were subject to regular review and included input as required from a specialist in behaviour support. Plans were responsive to individual needs and effective in supporting the staff team to provide consistent support to individuals.

Judgment: Compliant

Regulation 8: Protection

The registered provider had ensured all staff had been provided with training to ensure the safeguarding of residents. New staff members were scheduled to completed training during their induction.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider ensured that each resident's privacy and dignity was respected at all times. They were supported to engage in meaningful activities either within the designated centre or out in the community

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 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially 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 Red House OSV-0002650

Inspection ID: MON-0033386

Date of inspection: 24/10/2022

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: • All staff that required Fire Training completed same on the 17/11/22. Any further training requirements will be booked when required.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • Statement of purpose has been updated to reflect correct room sizes and to include all relevant information outlined in schedule one.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The following actions have been completed: • Dining room table and damaged chairs have been replaced. • Garden bench has been removed • Timber structures in the playground have been replaced • Items with rust in bathrooms have been removed / replaced • Damage to rubber seal on shower enclosure has been removed. Replacement of damaged floors – original contractor no longer available new quotes received on the 24/11/22. Date for completion of works to be agreed with new contractor, it is anticipated that works will be completed by 31/02/23.	

Options for replacing of radiators with rust to be escalated to senior management, it is anticipated works will be completed by 31/04/23.

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • Additional measures regarding fire safety have been discussed with staff at team meeting and additional checks that are required by staff are being monitored weekly by TL / PIC to ensure consistency.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • Isolation plan has been reviewed and signed by all staff. • IPC protocols in relation to the use of colour coded mops has been updated and are in place to guide staff practice.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Fire Doors have been reviewed by a competent person and a report on all maintenance requirements of fire doors has been received. Delay noted for works to be completed due to manufacturing delays – full schedule of works to be completed by 31/02/2023. • In the interim additional fire checks to be completed by all staff twice daily as a safety measure until works have been completed. This will be monitored by PIC/TL. • Minimal fire drill was completed on 26/10/22 and will be scheduled going forward.	

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	17/11/2022
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	30/04/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Substantially Compliant	Yellow	25/10/2022

	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	05/11/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	28/02/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	28/02/2023
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	Substantially Compliant	Yellow	26/10/2022

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
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	11/11/2022