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:	Hansfield Group - Community Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	25 March 2022
Centre ID:	OSV-0004040
Fieldwork ID:	MON-0035905

About the designated centre

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

The designated centre is located in North West Dublin and provides services though three units and an apartment adjacent to one of the units all of which are community based. Services are provided to persons with intellectual disabilities through 24 hour residential supports in the three units and supported living services in the apartment. The registered provider states that its central objective is to ensure that a safe, secure, supportive and caring environment is created which promotes the well-being of all residents. A person in charge and a team of social care workers and carers are employed in the centre to support residents.

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
Friday 25 March 2022	09:30hrs to 17:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This was an unannounced inspection undertaken in order to assess ongoing levels of compliance with the regulations. It took place during the COVID-19 pandemic and as such, the inspector followed public health guidelines throughout the inspection. The inspection had positive findings in many of the regulations such as safeguarding, risk management and fire. Some areas were found to require improvements such as premises, staffing, staff training and records. These will be outlined in detail in the body of the report.

The centre comprises three houses which are located in suburbs in West Dublin. The inspector visited all three houses in the company of the person in charge over the course of the day. One of these houses provides a residential service to four residents. This house has four single occupancy bedrooms, one of which is en suite. There is a large family bathroom. Downstairs is a sitting room, a kitchen/dining area, a toilet and a staff sleepover room. On the whole, this house was found to be in a good state of repair. It had a homely atmosphere, was warm and well ventilated. There were photographs of residents on the walls on holidays and days out. On arrival to the house, the inspector met with one resident. The resident initially chose not to interact with the inspector but chose to do so later in the day. They told the inspector that they were happy 'sometimes' in the house. The resident had been identified as not being compatible with one of their peers. An individual preferences and needs assessment was being carried out at the time of the inspection by the multidisciplinary team. The outcome of this assessment was to be referred to the providers admission, transfer and discharge committee for their consideration to accommodate the resident's request. Their bedroom was decorated in line with their interests and they had ample space for their personal belongings. The resident went out for coffee with a staff member in the morning and on their return wrote a letter to a family member. They showed the inspector some photographs of themselves engaging in activities they liked. Later in the afternoon, the inspector had the opportunity to meet the other three residents living in the house. One of them came in and out of the office observing the inspector and gave a thumbs up sign. They appeared content and comfortable. Another resident greeted the inspector and went up to their bedroom. They showed the inspector their balloon which they enjoyed getting each week. The fourth resident greeted the inspector while eating their dinner. They appeared happy and were well presented. Many of the residents in the house had complex communication needs and used a combination of words, Lámh signs and their own signs to interact. Interactions between the staff and residents were noted to be kind and respectful.

The second house has two adjoining units - a main house which provides a service to one resident with high support needs and an adjoining apartment which was vacant. The inspector did not have the opportunity to meet the resident who was competing in the Special Olympics that day. The exterior of the house, particularly the canopy on the porch was in a poor state of repair. There was a rusted hand rail which was not required by the resident on the side of the front door. Inside the

house, there had been a new wet room installed since the last inspection. The resident had ample space for their belongings. The resident in this house was supported to enjoy a wide range of activities. They were resuming attending a day service with staff support. The adjoining apartment had a side gate to the rear of the property and could also be accessed from the front door. In the third house, an individualised service was provided to a resident with complex support needs. The inspector briefly visited the premises as tolerated by the resident. The resident greeted the inspector and the person in charge. They were listening to music in the sitting room after being out for ice cream earlier that morning. The resident used Lámh and some of their own idiosyncratic signs to communicate. Staff told the inspector that they were working with a speech and language therapist to photograph and document these signs to ensure that all staff responded to the resident's communication in a consistent way. A visual for 'now' and 'then' was on the wall and in use to support the resident to understand their schedule. The resident was well presented and appeared to be content. Some of the areas of this house were found to be in a very poor state of repair. In the kitchen, the seal on one of the windows had electrical tape around it in order to reduce the draft. The kitchen had chipped counter tops and the cupboards were peeling at the front. The resident's bedroom was found to be a good size however, the en-suite required refurbishment. The shower was in a poor state of repair with the door requiring replacement.

The inspector viewed a sample of the family questionnaires which the provider had completed as part of their annual review. Feedback was positive with families stating that it "felt like an extended family" and that they were happy with familiar staff. Another family reported that they were happy with the resident's achievements but would have welcomed more stimulation. The resident had since returned to their day service. Residents meetings took place on a weekly basis and these meetings involved meal planning, sharing information about the plans for the week and the staffing and educating residents on making complaints and on safeguarding. Staff who were on duty in two of the locations were found to be knowledgeable about residents' assessed needs and the areas they required additional support in.

In summary, this was a largely positive inspection which found some areas which required improvements in premises, staffing, staff training and infection prevention and control. Residents appeared to be happy and comfortable in their homes. They were well presented and found to be treated with dignity and respect by the staff. The next two sections of this report present the inspection findings in relation to the governance and management of the centre and how governance and management arrangements affected the quality and safety of the service being delivered.

Capacity and capability

The provider had good management systems and processes in place to oversee and ensure residents were receiving a safe good quality service. There was a clear

management structure in place. The provider had completed six monthly reviews and annual reviews as required by the regulations. The annual review from 2020 was viewed by the inspector and this included consultation with residents and their families. However, while the six monthly unannounced visits were taking place, the provider was not present in all parts of the centre for these visits. This meant that oversight of the houses was not consistent. There were clear action plans developed by the person in charge from the annual and six monthly reviews. These action plans were reviewed on a quarterly basis, with an associated action log kept.

Staff meetings took place for each house on a monthly basis. A 'designated centre' meeting involving all three houses occurred twice a year. There was a set agenda in place for these meetings. Further communication took place between the staff team and the person in charge through a staff meeting memo. The person in charge met with their manager once a month where progress on action plans arising from audits were reviewed.

The provider had appointed a suitably qualified and experienced person in charge. They worked in a full-time capacity and their post was supernumerary. They had a longstanding knowledge of the residents and their assessed needs. They were a member of the ethics and restrictive practice committee and had completed training to enable them train other staff in the management of behaviours of concern. The person in charge oversaw a number of audits in the centre. These took place in areas such as risk assessments, incidents and accidents, medication and finances.

The provider had resourced the centre with a staff team who were suitably qualified to provide support to the residents in the centre. The inspector reviewed a sample of rosters from each house. While they were mostly well maintained, there were some gaps in the names of relief staff who had completed shifts. On another roster, it was unclear what exact shift a staff member had worked. A review of a sample of schedule 2 files which took place prior to the inspection found that all information required by the regulations in respect of staff were kept on their files.

Staff training had improved since the last inspection. Staff had completed mandatory training in areas such as safeguarding, fire safety, safe administration of medication and manual handling. However, four of the staff had not done any training on the management of behaviours of concern. Another five staff had completed their initial training between 2016 and 2018 and had done no refresher training. This was a significant gap due to the support needs of the residents in the centre. Choking was another identified risk and staff had not completed first aid training to ensure they were equipped to deal with an emergency were it to arise. Supervision with staff took place twice a year and in addition to this, an annual performance management review took place. Where there was any significant incident, staff were supported to a de-brief with the person in charge shortly after each one. Staff whom the inspector spoke with reported to be well supported in their roles.

The provider had prepared a statement of purpose which met regulatory requirements, it was regularly reviewed and reflective of the services noted on inspection. A review of the incident and accident log indicated that all notifiable

events were notified to the Office of the Chief Inspector within required time frames.

Documentation required improvement in some areas. However, these did not pose a significant risk to residents. For example, many of the care plans had duplication of some information such as hospital passports and older information on file relating to care plans. Some of these issues had been identified by the provider and work was in progress to offer education and support to staff in ensuring care plans and person centred plans were complete and up to date. Maintenance requests and records also needed improvement in order to ensure adequate oversight of what issues had been reported, by whom and whether they had been completed or not. These areas required attention in order to ensure that staff practice was guided with up-to-date information about residents and to enable oversight of all maintenance issues and reporting of these across the three houses.

Regulation 14: Persons in charge

The provider appointed a suitably qualified and experienced person in charge. They worked in a full time capacity and had good knowledge of the residents and their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

The provider had an adequate number of staff who had the required training, experience and qualifications to support the residents. From a review of rosters it was evident that for the most part, residents had good continuity of care with use of regular relief staff where they were required. The planned and actual rosters were mostly well maintained. However, there were some gaps in rosters such as names missing of staff who had completed shifts.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had completed mandatory training in a number of key areas such as safeguarding, fire safety and manual handling. However, there were significant gaps in staff training related to the management of behaviours of concern. Four staff members had not completed it and were scheduled to do so. Five other staff were last trained between 2016 and 2018. First aid training had not been completed where there was an identified risk of choking for residents. Staff had supervision

sessions twice a year.

Judgment: Substantially compliant

Regulation 21: Records

While documentation was adequate in some areas, other areas such as care plans and a maintenance log required improvement to ensure they allowed the person in charge to have oversight and to clearly guide staff practice.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had good management systems and processes in place to oversee and ensure residents were receiving a safe good quality service. There was a clear management structure in place. Staff had access to out of hours management support at all times. The provider had completed six monthly reviews and annual reviews as required by the regulations. However, the six monthly reviews were not ensuring the provider was present in all parts of the centre and therefore oversight of all of the houses was not consistent. The annual review from 2020 was viewed by the inspector and this included consultation with residents and their families. There were clear action plans developed by the person in charge following on from this and the six monthly reviews. These action plans were reviewed on a quarterly basis, with an associated action log kept.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider prepared a Statement of Purpose. This was regularly updated and was found to be reflective of the services provided to residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector found that all notifiable incidents were reported to the Office of the

Chief Inspector within required time lines.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were in receipt of a good quality service which was striving to ensure residents had a good quality of life. Residents had access to a range of health and social care professionals such as social work, psychiatry, psychology, speech and language therapy, physiotherapy and occupational therapy. A multidisciplinary team meeting took place for the designated centre each quarter. Residents also had access to a clinical nurse specialist in infection prevention and control and the provider had recently employed a community health nurse.

Residents' personal behaviour support plans were reviewed every three months. A sample of plans the inspector viewed were found to be person -centred and to outline both proactive and reactive strategies for staff to use with the residents who required support. There was a restrictive practice register in place and this was regularly reviewed by the multidisciplinary team. Trials of reducing some restrictions had taken place and the person in charge had completed 'impact assessments' every quarter to consider the impact which restrictions were having on other residents in the house. There was easy to read information about the rationale for restrictive practices in place. PRN protocols were clearly outlined. As stated earlier in the report, there were significant gaps in staff training in this area and this is captured under regulation 16.

There were a number of policies and procedures in place to ensure that residents were safeguarded from abuse in the centre. Any safeguarding incidents which had occured were found to be appropriately identified, documented and investigated in line with National Policy. An action plan had been developed to identify a compatibility issue between two of the residents. A sample of intimate care plans demonstrated that the plans were very detailed, person centred and respectful of residents' rights to privacy and dignity. Consent was sought for care plans from residents. Residents' finances were protected by a clear system of signing money in and out and regular audits took place.

The inspector visited all three of the properties on the day of the inspection. The first house was found to be in a good state of repair. It was homely and warm with pictures of the residents on the walls and some of their belongings which they enjoyed in the sitting room. Each resident had their bedroom personalised and had ample space for their belongings. One resident had an en suite bathroom. New chairs, blinds and carpets had been ordered for the house. Some maintenance issues with bathrooms, painting and flooring had been mostly self-identified by the provider and were logged with the maintenance department. However, it was

unclear what progress had been made on these items as the record of each item was kept on paper for items reported. The second house has two adjoining units - a main house and an adjoining apartment which was vacant. The exterior of the house, particularly the canopy on the porch was in a poor state of repair. There was a rusted hand rail which was not required by the resident on the side of the front door. Inside the house, there had been a new wet room installed since the last inspection. The resident had access to a kitchen/dining area and a sitting room downstairs and their bedroom was upstairs next to the staff office. The adjoining apartment had a side gate to the rear of the property and could also be accessed from the front door. The apartment was generally in a good state of repair with the exception of the shower which required replacement. In the garden to the rear of the property was a shed which had been made into a laundry room. This was found to be in very poor condition. There was mould on the roof and the cupboards required replacement. The third property was found to be in a poor state of repair in the kitchen and the resident's en suite bathroom. The kitchen had chipped cupboards and one of the windows had electrical tape on it to reduce a draft. The shower in the resident's room had broken runners, tiles cracked and it was rusted and peeling at the bottom. Again, while this was reported, it was unclear what the status was of these reports.

The provider had good risk management systems in place. Risks were found to be appropriately identified , assessed and managed. The risk register had been recently updated for the centre to ensure ongoing oversight of all identified risks. Where adverse events did occur, these were documented and reported appropriately to senior management. There was evidence of learning from adverse events and this learning was shared with staff. Staff were given the opportunity to debrief with the person in charge after events where this was required.

The inspector found that the provider had put a number of measures in place to protect residents from infection. There were policies, procedures and guidelines in place to guide staff practice including areas such as infection prevention and control (IPC), hand hygiene and cleaning and disinfection. The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. This had been reviewed within the last quarter as required. Cleaning schedules were in place and checked by the person in charge regularly. The centre had access to a Clinical Nurse Specialist in Infection Prevention and Control. A recent IPC audit had taken place. This had identified maintenance issues as having a negative impact on infection prevention and control measures in two of the three houses. The inspector noted that regular flushing of water was not taking place in the vacant apartment in one of the properties.

The provider had good fire safety management systems in place. Each house had smoke alarms and fire doors with swing closers fitted on appropriate areas of the houses. Fire fighting equipment was available and regularly checked. Emergency lighting was in place. Regular checks of equipment were taking place in addition to servicing and maintenance from external companies. Residents had personal

emergency evacuation plans developed and these were regularly reviewed. Fire drills took place in each location and where required, actions were identified to reduce any risks. Drills demonstrated reasonable egress times.

Regulation 17: Premises

As outlined in the body of the report, many parts of the houses were found to be warm and homely and importantly, they were found to be suited to the assessed needs of the residents. There were issues with four of bathrooms in the three premises. The outside of the second house was in a poor state of repair.The apartment adjoining the second house was generally in a good state of repair with the exception of the shower which required replacement. In the garden to the rear of the property was a shed which had been made into a laundry room. This was found to be in very poor condition. There was mould on the roof in addition to a hole in the roof. The third property was found to be in a poor state of repair in the kitchen and the resident's en suite bathroom. The kitchen had chipped cupboards and one of the windows had electrical tape on it to reduce a draft. The shower in the resident's room had broken runners, tiles cracked and it was rusted and peeling at the bottom. While most of these issues had been identified, it was not clear what issues were reported to maintenance and what status they were at.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had good risk management systems in place. Risks were found to be appropriately identified , assessed and managed. The risk register had been recently updated for the centre to ensure ongoing oversight of all identified risks. Where adverse events did occur, these were documented and reported appropriately to senior management. There was evidence of learning from adverse events and this learning was shared with staff. Staff were given the opportunity to debrief with the person in charge after events where this was required.

Judgment: Compliant

Regulation 27: Protection against infection

The inspector found that the provider had put a number of measures in place to protect residents from infection. There were policies, procedures and guidelines in place to guide staff practice including areas such as infection prevention and control

(IPC), hand hygiene and cleaning and disinfection. The Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool had been completed and was regularly reviewed. Cleaning schedules were in place and checked by the person in charge regularly. The centre had access to a Clinical Nurse Specialist in Infection Prevention and Control. A recent IPC audit had taken place. This had identified maintenance issues as having a negative impact on infection prevention and control measures in two of the three houses. The inspector noted that regular flushing of water was not taking place in the vacant apartment in one of the properties.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had good fire safety management systems in place. Each house had smoke alarms and fire doors with swing closers fitted on appropriate areas of the houses. Fire fighting equipment was available and regularly checked. Emergency lighting was in place. Regular checks of equipment were taking place in addition to servicing and maintenance from external companies. Residents had personal emergency evacuation plans developed and these were regularly reviewed. Fire drills took place in each location and where required, actions were identified to reduce any risks. Drills demonstrated reasonable egress times.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' personal behaviour support plans were reviewed every three months. A sample of plans the inspector viewed were found to be person -centred and to outline both proactive and reactive strategies for staff to use with the residents. There was a restrictive practice register in place and this was regularly reviewed by the multidisciplinary team. Trials of reducing some restrictions had taken place and the person in charge had completed 'impact assessments' every quarter to consider the impact which these restrictions were having on other residents in the house. There was easy to read information about the rationale for restrictive practices in place. PRN protocols were clearly outlined. As stated earlier in the report, there were significant gaps in staff training in this area and this is captured as a finding under regulation 16.

Judgment: Compliant

Regulation 8: Protection

There were a number of policies and procedures in place to ensure that residents were safeguarded from abuse in the centre. Any safeguarding incidents which had occured were found to be appropriately identified, documented and investigated in line with National Policy. An action plan had been developed to identify a compatibility issue between two of the residents. A sample of intimate care plans demonstrated that the plans were very detailed, person centred and respectful of residents' rights to privacy and dignity. Consent was sought for care plans from residents. Residents' finances were protected by a clear system of signing money in and out and regular audits took place.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hansfield Group - Community Residential Service OSV-0004040

Inspection ID: MON-0035905

Date of inspection: 25/03/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Actual Rota now amended to reflect staff names where they were absent on 2 rosters. The PIC shall ensure that the actual and planned rotas will show staff on duty during the day and night and will be properly maintained going forward.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Since inspection, 15 staff have now completed the Management in Challenging Behaviour course with a further 6 listed for the next available training date. First Aid training will be escalated to the Service Manager and Training Co-ordinator.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Any duplicated documents in care plans have now been removed. The PIC has set up a Designated Centre Maintenance List to facilitate with oversight of maintenance issues.	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
the Service Providers 6 monthly reviews will now comprise of visits to all parts of the designated centre to provide consistent oversight to all houses within the designated centre.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider acknowledges the identified issues with one of the houses and is exploring all possibilities to address these. All other areas identified have been re submitted on the Designated Center Maintenance list to the Services Manager and will be monitored by the PIC and PIMM through a developed action plan to provide oversight and completion of these issues.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Maintenance issues as identified as having a negative impact on IPC measures have been re submitted on the Designated Center Maintenance list to the Services Manager and will be monitored by the PIC and PIMM through an developed action plan to provide oversight and completion of these issues.

A procedure and record of the regular flushing of water is now in place in the vacant apartment in one of the properties.

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 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	03/05/2022
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	30/11/2022
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	Not Compliant	Yellow	31/12/2022

	internally.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Yellow	03/05/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/07/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated	Substantially Compliant	Yellow	03/05/2022

	infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			