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:	Brookfield
Name of provider:	Praxis Care
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	17 December 2019
Centre ID:	OSV-0005686
Fieldwork ID:	MON-0024760

About the designated centre

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

Brookfield is a community home for up to five adults with an intellectual disability. The service can support both male and female residents. The house is located in County Dublin and is a two-storey detached home with six bedrooms. It has been recently renovated to meet the needs of residents residing in the centre. Each resident has their own bedroom with an en-suite bathroom. There is a sitting room, quiet room, downstairs toilet and a spacious kitchen/dining/living area. There is also a separate utility room in the back garden. The back garden has been adapted to meet residents' needs. The house is located in close proximity to public transport and a wide variety of social, recreational, educational and training facilities. The house is social care led and residents are supported 24 hours a day, seven days a week.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 - 2015 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
17 December 2019	09:30hrs to 17:30hrs	Marie Byrne	Lead
17 December 2019	09:30hrs to 17:30hrs	Gearoid Harrahill	Support

What residents told us and what inspectors observed

The inspectors of social services had the opportunity to meet four of the five residents living in the centre during the inspection. Throughout the inspection, residents appeared comfortable in their home and with the support offered by staff. Residents were observed coming and going from the centre throughout the day to activities, appointments or day services in line with their wishes and preferences.

Residents who spoke with the inspectors described what it was like to live in the centre and how they were supported to engage in activities and reach their goals by staff in the centre. They all spoke fondly of staff members and the support they received while living in the centre. One resident described plans to go on holidays to a hotel after Christmas and other activities they were supported to engage in, during the run up to Christmas. A vehicle had been secured for the centre since the last inspection, and this resident referred to what a difference this had made for them in relation to opportunities to access their local community. One resident described the importance of fun in their life and described some fun times and interactions which they had with staff. They said they currently had no complaints but were aware of the process and had used it in the past.

The inspectors observed one resident preparing dinner. They completed the preparations for the meal, cooked it and then were observed to sit and enjoy this meal they had just prepared. They also proudly showed the inspectors some home baking which they had made in their day service. While speaking with this resident, they also described their plans for the evening and things they had to look forward to in the coming weeks. Another resident showed the inspectors pictures of a recent trip to a local shopping centre to take part in the Christmas festivities

Warm interactions were observed and heard between residents and staff during the inspection. Residents and staff were singing Christmas songs at intervals, chatting in the kitchen and engaging in activities both at home and in their local community. Residents were observed receiving support in a discreet and respectful manner, and were only supported when they requested support. Their independence was being encouraged at every opportunity.

Capacity and capability

Overall, the inspectors found that the provider and person in charge were monitoring the quality and safety of care and support for residents. They were identifying areas for improvement and putting plans in place to complete the

required actions to make these improvements.

This inspection was facilitated by the person in charge. They were found to be knowledgeable in relation to residents' care and support needs and their responsibilities in relation to the residents. They were motivated to ensure that residents had a good life and making every effort to ensure they were engaging in day services, volunteering and activities in line with their wishes and preferences.

The person in charge was supported in their role by the person participating in the management of the designated centre (PPIM) and there were management systems in place to monitor the quality and safety of care and support for residents and to support staff to carry out their roles and responsibilities to the best of their abilities. The provider was completing an annual review of care and support in the centre and there was evidence of six-monthly reviews by the provider or their representative. In addition, a number of audits were being completed in the centre regularly. There was evidence that these reviews were picking up on areas for improvement in line with those identified during this inspection. However, some of the actions identified in these reviews had not been completed in line with the timeframes identified by the provider. For example, they had identified the requirement to complete works to a number of doors in the centre to improve accessibility for residents and these works had not been completed. There was no evidence of residents' or their representatives' consultation in the latest annual review of the quality and safety of care and support in the centre.

Staff meetings were occurring regularly and there was evidence that the agenda items were person-centred and varied from month to month. There was evidence that information was shared at these meetings as was learning following significant events. Handover was completed daily at the change of staff shifts. These were not being consistently documented. In addition, there were gaps in other records in the centre such as update of risk assessment plans following the implementation of new restrictive measures or following the addition of safeguarding measures. However, these gaps were not leading to immediate risks for residents as staff were knowledgeable in relation to these changes. The provider had identified some of these gaps in their latest six-monthly review and plans were in place to review and update a number of documents. The PPIM was visiting the centre regularly and completing monthly audits in the centre. There was a quality improvement plan in place in the centre and evidence that the majority of actions were closed off in this plan.

There was a skilled and competent team of staff to support the residents in accordance with their needs and preferences. Staff were knowledgeable of residents' support needs, personalities and interests, and inspectors observed a friendly, respectful relationship between staff and residents. Residents spoke positively of staff and how they were supported by them in their daily lives.

There was an active planned and actual roster which clearly outlined staff numbers and shift patterns, and this was being kept under review based on changing support needs. There were no vacancies in staff numbers at the time of inspection, and the provider had arrangements in place to prepare for upcoming changes in personnel

to ensure a smooth transition and continuity of support for the residents.

Staff were supported by management to carry out their duties effectively. Inspectors reviewed records of regular supervision and appraisal systems in use for staff. These meetings identified strengths and areas for development by staff members as well as objectives for the coming year on how they could more effectively care for and support residents. Staff had attended training in fire safety, manual handling and safeguarding of vulnerable adults, and had also been trained in areas of care related to the specific needs of the residents in the centre, such as epilepsy care and personal safety. Inspectors reviewed a sample of personnel files, which contained all required documents under Schedule 2 of the regulations, including vetting by An Garda Síochána and evidence that staff were suitably qualified and experienced for their role.

The inspectors reviewed the records relating to one resident's recent admission to the centre and found that this admission had been completed in line with the organisation's policies and procedures and in line with the centre's statement of purpose. There was evidence that the provider had considered the needs and safety of this resident and of other residents living in the centre, during the admissions process. The inspectors reviewed a sample of residents' contracts of care and found that they were in place, signed by the resident or their representative and clearly outlined details of the support, care and welfare to be provided, the services and facilities provided and the fees to be charged.

The centre maintained a complaints policy and procedure, including a version in an accessible format. This identified the persons responsible for managing and responding to complaints. Residents told inspectors that they would feel comfortable making a complaint if needed. Records of complaints included details on the issues, the correspondence between the provider and complainant, and the outcome of the matter, including whether the person was satisfied with the resolution. Arrangements were in place for how complaints would be reviewed if the person was not satisfied. Verbal complaints were documented and responded to with the same level of importance as those received in writing.

Regulation 15: Staffing

Inspectors found that there was a suitable number of staff to support residents, their needs and routines, with a planned and actual roster which facilitated this delivery of care and support. Staffing numbers were kept under review based on changing circumstances and the provider had made preparations to provide continuity of support with upcoming changes in staff placement.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were suitably trained to meet the needs of the residents and staff were up to date in their mandatory training including fire safety, manual handling, and safeguarding of vulnerable adults. Staff had also attended a range of additional training based on the needs of the residents in the centre. There was a clear support structure in place for staff and arrangements for supervision and appraisal had been carried out.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the centre was well managed There were clearly defined management structures and staff were clear on their responsibilities in relation to providing a good quality and safe service for residents. There were systems in place to monitor the quality of care and support for residents including the annual and six-monthly reviews by the provider or their representative. The provider was identifying areas for improvement in line with the findings of this inspection and had plans in place to complete the required actions. However, a number of these actions had not progressed in line with the identified timeframes and there was no evidence of residents' or their representatives' consultation in the latest annual review of the centre.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There was an admissions policy and procedures in place and the inspectors found that a recent admission to the centre had been completed in line with these and the centre's statement of purpose. The sample of contracts of care reviewed, contained the required information and had been signed by the resident or their representative.

Judgment: Compliant

Regulation 34: Complaints procedure

The centre maintained a policy and procedure for making complaints and residents

felt comfortable that they could make a complaint and that it would be addressed properly. The provider maintained a log of written and verbal complaints received and the actions and learning taken from same.

Judgment: Compliant

Quality and safety

Overall, residents were in receipt of a good quality and safe service. Residents described the things they liked to do and discussed things they had to look forward to. They lived in a nice home and were complimentary towards the house they lived in and the staff team who supported them.

The premises consisted of a detached two-storey house in a housing estate which provided private bedrooms for all residents with en-suite toilet and shower facilities. The house was warm, comfortable and well maintained, and was nicely decorated for Christmas. The building overall was homely in its design, and bedrooms were well-personalised based on residents' wishes and preferences. Some communal areas had been laid out to be used for residents' hobbies and for them to relax in less busy areas of the house. There was a safe and accessible garden including a designated smoking area. Overall the house was designed and adapted for use by all residents, and residents were satisfied with the size and layout of the house. The provider had identified a deficit in the ability of residents with mobility requirements to navigate the house independently. While action had been identified and was in progress to rectify this, at the time of inspection it had not been completed in line with the timeline set out by the provider. The resident impacted by this described difficulties opening a number of doors and how they currently relied on staff to support them. They were aware that works were due to be completed to remedy this.

Residents had an assessment of needs in place and a personal plans which were person-centred and reflective of residents' care and support needs. There were additional documents in place which gave a quick synopsis of residents' care and support needs and emergency information and contact details. For example, residents had personal information sheets and emergency grab sheets. In addition, there were other areas of good practice such as a 'this is me' document. This document included information which was important to the resident now and for their future. The sections reflect what people admire about the resident and what good support looks like for them. Residents had an accessible version of their personal plan available. There was evidence that residents had access to a keyworker and that they were meeting with them formally at least once a month to review their wellbeing, safety, and any other areas which the resident wished to discuss. There was evidence throughout residents' documents of their involvement in their development and review, including opportunity for them to sign them. Social stories were developed as required with residents to support them in

their day-to-day lives.

There were a number of restrictive practices in the centre and there was evidence that these were reviewed regularly to ensure they were the least restrictive for the shortest duration. Residents were supported by the relevant allied health professionals and positive behaviour support plans were developed and reviewed as required. They clearly guided staff to support the residents using proactive and reactive strategies. In response to an increase in incidents in the centre, the person in charge had arranged for a review of positive behaviour support for residents in the centre to ensure they were best suiting their current needs.

Residents were protected by the policies, procedures and practices relating to safeguarding residents in the centre. All allegations or suspicions of abuse were reported and followed up on in line with the organisation's and national policy. In response to an increase in safeguarding concerns in the centre, additional measures had been put in place to keep residents safe such as 1:1 staffing for residents as required and the implementation of measures outlined in the safeguarding plans. Staff had access to training and refreshers to support them to be aware of their roles and responsibilities in relation to safeguarding. Those staff who spoke with the inspectors were found to be knowledgeable in relation to their roles and responsibilities and the control measures outlined in safeguarding plans. Residents had intimate care plans in place and they clearly outlined residents' care and support needs and preferences.

The centre was equipped with features to effectively detect and contain the spread of flame and smoke in the event of a fire. The centre utilised an addressable fire detection system and panel and the house was appropriately equipped with emergency lighting and evacuation and assembly point signage. All equipment and safety features were subject to regular checks and certification. The centre’s risk register identified and listed control measures for risks related to fire, such as smoking.

Practice evacuation drills were conducted in the centre which kept the staff and residents in good practice on how to efficiently and safely get out of the building. Records of these drills identified the procedures followed and elements of evacuation which may cause delay. There was clear evidence of the management using this practice to provide learning opportunities to staff and residents for future reference. All residents had a personal emergency plan clearly indicating their assistance and communication needs in the event of emergency, on which staff were knowledgeable.

Residents were supported to spend their day in accordance with their individual choices, interests and preference. Residents were supported to attend day services and appointments with staff members. Residents also spoke with inspectors about various concerts, shopping trips, local events and social outings they went to with support staff or with their friends. The centre had acquired an accessible service vehicle, and the residents told inspectors that it had greatly enhanced their ability to get out into the community to meet with friends or go into town.

In addition to residents speaking positively about staff, inspectors observed respectful and friendly interactions between staff and residents. Staff were observed chatting and joking with residents and delivering support and assistance in a manner which was discreet and dignified. Residents had also been consulted on the use of their personal information and their consent was attained before using any photos or videos for internal communication or social media by the provider.

Resident feedback on the operation of the service was sought via regular resident committee meetings, the agendas of which were tailored to the suggestions and interests of the residents and contained items for follow-up by the next meeting.

Residents were supported to manage their own belongings and money. There were clear instructions and guidance for each person on the level of support needed to manage their bills and banking. Where staff held on to residents' belongings or cash, there was a system in place to ensure this was kept secure, safe and accessible when required by the residents. Residents were supported to exercise their civil rights around voting in line with their wishes.

The inspectors reviewed a number of transition plans for residents in the centre and found that they were detailed and showed evidence that residents' transition were planned and completed in line with residents wishes and at a pace suitable to them. One resident was temporarily absent from the centre at the time of the inspection and there was evidence that the relevant information had been shared by the team in the centre to the relevant people.

Residents were protected by the systems in place relating to risk management. There was a centre-specific risk register in place and evidence that it was regularly reviewed and updated. Residents had risk assessment and management plans in place and there was evidence that these were reviewed and updated in line with residents' changing needs and learning following incidents. There was a safety statement and emergency plans in place, evidence of regular health and safety inspections, and checks and servicing of equipment.

Regulation 12: Personal possessions

Arrangements were in place for residents to maintain control of their personal possessions and clothing. Staff supported residents to access and manage their money, and systems were in place for staff to retain belongings for residents in a safe and secure manner.

Judgment: Compliant

Regulation 17: Premises

The premises were homely, comfortable and well-maintained, with residents satisfied with their living arrangements. The provider had identified an aspect of the centre which limited resident accessibility, and arrangements to rectify this were in progress. However, at the time of inspection the action identified had not been completed within the planned timeframe.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

Transitions were being completed in line with the centre's policies, procedures and statement of purpose. There was evidence that they were being completed at a pace suitable for residents and completed in a planned and safe manner.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by the risk management policies, procedures and practices in the centre. There was a risk register in place and residents had individual risk management plans. There was evidence that these were reviewed and updated regularly.

Judgment: Compliant

Regulation 28: Fire precautions

The building was equipped to detect and contain fire, with an addressable fire alarm system and suitable emergency lighting and signage in place. All equipment and fire doors were serviced and checked regularly. Practice evacuation drills had taken place in the centre and staff and residents were knowledgeable of what to do in the event of an emergency evacuation.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents had an assessment of need and personal plans which clearly guided staff

to support them with their care and support needs. There was evidence that these documents were reviewed and updated regularly. Residents had access to a keyworker to support them with this and to set and achieve their goals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Restrictive practices in the centre were reviewed regularly to ensure that the least restrictive measures were used for the shortest duration. Positive behaviour support plans were developed as required to support residents. They were detailed and clearly guiding staff to support residents. Plans were in place to further review supports for residents in the centre to ensure they were being supported in line with an increase in incidents in the centre.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. Staff were in receipt of training and refreshers to ensure they were aware of their roles and responsibilities in relation to safeguarding. Safeguarding plans were developed as necessary and staff were knowledgeable in relation to the implementation of these plans.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider supported the residents to participate in the running of the service, and resident support and daily life was driven by the residents' choice and preferences. Care and support was delivered in a manner which was respectful and friendly which respected each person's privacy and dignity.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Brookfield OSV-0005686

Inspection ID: MON-0024760

Date of inspection: 17/12/2019

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.
The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their

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(1)(a)
Brookfield has in place a full staff team consisting of a full time person in charge, a part time team leader and a support staff of 7 WTE support staff.
(1)(b)
Brookfield is managed by the person in charge, support staff report to the person in charge and the team leader.
The person in charge reports to the Head of Operations for the service, who in turn reports to the ROI Director of services.
The Head of Operations is a registered PPIM.

(1)(C) / 2 (a)(b)
The Head of Operations conducts monthly audits within the service, to ensure the service is safe and appropriate to resident's needs.

The service is subject to internal unannounced six monthly and annual inspections to monitor service quality and compliance. Any areas of high risk are escalated to director level.

The service is also subject to unannounced inspections by Praxis Cares Quality and Governance department.

Each of the above audits result in an action plan, and completion of identified actions will be time bound.

Actions from all audits will be carried out by the PIC within the allocated time frames.

The Head of Operations will monitor the timely completion of audit actions, during the PIC's formal supervision with and during each monthly audit of the service.

The service has in place an overall quality improvement plan, this will ensure that overall completion of identified actions is tracked by the PIC.
Progress on the quality improvement plan, will be reported on a weekly basis to the Head of Operations and on a monthly basis to the Director of care.

Each of the above stages of monitoring will further ensure that all actions are completed with allocated time frames.

The service currently has 14 outstanding actions, that are identified through the above audit systems and these will actioned and monitored by the Head of Operations and PIC and closed by the 10.03.2020.

(1)(d)
The service is subject to internal annual review and this was last conducted on the 29.08.2019

(1)(e)
An annual review of the service was conducted on the 29.08.2019, however it failed to capture the views of the residents and representatives.

The service will conduct a service user and stakeholder survey on a yearly basis and prior to completion of the annual review. This survey will be conducted in a manner that meets each service users communication needs.
The view and actions from this survey will be captured in the annual review.
Actions identified from the service user and stakeholder survey and required actions will be added to the service Quality Improvement Plan.

1(f) There are copies of the report as noted in (d) available within the service for access by service users and can be made available to the chief inspector on request.

(3)
All staff receive formal supervision by their line manager (PIC / TL) on a bi monthly basis. This supervision process, ensures staff are supported to develop and meet their personal and professional responsibilities, and that the PIC addresses any areas of performance development.

All staff receive a formal annual appraisal of performance.

B)
There are complaints and grievance policy and procedures in place

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.

(17)(1)(a) The premises is designed and laid out in a manner which meets service user needs, one service user requires wet room shower facilities and these are in place. One service user requires wheelchair access and the premises is laid out to enable wheelchair access to the entire ground floor. However as identified in 17 (6) there is a need for automated access to external doors.
Each service user had their own bathroom and en-suite and there are three sitting rooms for use by service users.
B) The center was renovated in 2018 prior to service users moving in. This was overseen by Praxis Care development department, all building works are signed off and approved in line with building regulation.
C) The service has in place comprehensive cleaning schedules which are adhered to and monitored by the PIC.

(2) – Not applicable as no children reside in the service.
(3) - Not applicable as no children reside in the service.

(4)(5)
One resident has assistive equipment in the form of hospital bed, Moulded wheelchair, sling and hoist.
This equipment is serviced regularly and in line with manufactures guidelines. Records of all maintenance carried out is held within the service.

6)
The service is designed and laid out to promote all service users accessibility.
During inspection it was identified that one service user requires automated door access on bedroom and external doors.
The service provider has obtained quotations for the works required.
The service provider will put in place the required automated door openings by the 31.03.2020.

7) Yes all requirements of schedule 6 are in place.

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 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/03/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate	Substantially Compliant	Yellow	31/03/2020

	to residents' needs, consistent and effectively monitored.			
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/01/2020