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:	B Bettystown Avenue
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	28 September 2021
Centre ID:	OSV-0002364
Fieldwork ID:	MON-0026536

About the designated centre

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

B Bettystown Avenue is a designated centre operated by St. Michael's House. The centre is a community based semi-independent home for up to three adult residents with an intellectual disability. Residents are supported to become as independent as possible in the centre. The premises consists of a two-storey three bedroom house with a kitchen/dining room, a sitting room and two bathrooms. A small garden area and driveway is available to the front of the premises, with a larger garden area to the rear of the premises. The centre is situated in a suburban area close to a range of community amenities and public transport links. Staff encourage residents to be active members in their communities and to sustain good relationships with their family and friends. Staff are primarily available to support the residents in the afternoon, evening and at weekends. Outside of these times, if they require support, residents can utilise an on-call facility or make contact with staff in another centre within close proximity of their home. The centre is managed by a person in charge and a staff team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Tuesday 28 September 2021	9:40 am to 4:40 pm	Jennifer Deasy	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet with several of the residents on the day of inspection. The inspector wore appropriate personal protective equipment (PPE) and maintained social distancing in line with the current public health guidance during all interactions with residents and staff. All residents had completed HIQA resident questionnaires and these were made available to the inspector. The inspector used the detail of these questionnaires, along with conversations with residents and key staff, observations and a review of documentation to make a judgment of the quality and safety of care within the designated centre. Overall, the inspector found that residents were receiving a good quality service and that they were safe in their home.

Through conversations with residents and a review of their questionnaires, the inspector was informed that residents felt happy in their home. Residents told the inspector that they were satisfied with the food and meals available to them, that their rights were respected and that they have choice and control over the decisions that affect their lives. Residents reported that they got on very well with each other and that there was seldom any conflict. One resident reported that they would like to live independently. They said that this was due to a desire to be independent and not due to any issues with the designated centre. This resident described the supports that they were receiving in order to live independently. The resident stated that they were happy with the progress towards their goal of independent living.

It was clear to the inspector that the residents were part of their local community. Residents were seen coming and going from the centre independently on the day of inspection. Some residents had paid employment in the community. Others accessed courses in further education or related to their individual interests in community colleges and centres in the area. Residents cycled or took the local bus to their place of work or study.

The inspector observed that staff and resident interactions appeared friendly and warm. Staff were observed supporting residents with meal preparation. Their communication was observed to be respectful and their conversation related to the residents' specific interests. Staff spoken with appeared to know the residents well. Staff were aware of resident's individual needs and were particularly conscious of the risks which could present to residents living semi-independently in the community. Staff could describe the measures which had been implemented to mitigate against known risks.

The designated centre was noted to be generally clean and tidy. Residents showed the inspector the recreational activities which they enjoy in the designated centre. These included art, gardening, puzzles and growing vegetables. Some residents were in the process of refurbishing their bedrooms and they were receiving support from staff with this. Two residents showed the inspector their bedrooms. Their bedrooms were noted to be decorated according to individual preferences. Residents

had access to their own televisions in their bedrooms and had access to other technologies including their own mobile phones with relevant assistive technology applications. The staff had also recently purchased, through the provider's technology fund, a computer tablet for all residents' use.

There were some premises issues which required addressing by the provider. These included kitchen refurbishment, garden maintenance, window repairs and general painting. These will be discussed further in the quality and safety section of the report. Residents reported that there were areas which they would like to see improved in relation to the premises. Residents expressed a wish for a covered area in the garden to facilitate smoking access in bad weather. One resident reported that their bedroom is quite small and that they would like more space for storing their belongings. Additionally, residents reported that the bedrooms can be cold at night.

Overall, the inspectors found that the residents in this centre were supported to enjoy a good quality of life which was respectful of their wishes and choices. The person in charge and staff were striving to ensure that residents lived in a supportive environment. It was clear that residents were being supported to develop meaningful relationships and connections in their community. It was evident that residents' views were listened to and that their autonomy was respected.

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

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to inform decision making for the renewal of the centre's registration. The inspector found that this centre met and exceeded the requirements of the regulations in many areas of service provision.

An application to renew the registration of the designated centre had been submitted to the Chief Inspector of Social Services within the required time frame. This application was reviewed by the inspector and was found to include all of the relevant information as required by the Registration of Designated Centres Regulations, Regulation 5, in particular the information as set out in Schedule 2 and Schedule 3 of the regulations. The application form was accompanied by the prescribed fee. Proof of the registered provider's contract of insurance was submitted along with the application form.

A statement of purpose was found to be in place in the designated centre and was easily accessible to residents. The statement of purpose was reviewed and was found to contain all of the information as required by Schedule 1 of the regulations.

There were effective management arrangements in place that ensured that the safety and quality of the service was consistently and closely monitored. The provider had systems in place to monitor and review the quality of services provided within the centre such as six monthly visits and an annual review. The annual review of quality and safety was carried out in consultation with the residents and clearly documented their views of the service. There was evidence that resident feedback which had been gathered through the annual review had been taken on board and actioned by the provider. For example, the annual review detailed that several residents wished to redecorate their bedrooms. This had been captured in individual resident plans and, at the time of inspection, these works were ongoing.

Six monthly visits were also completed in consultation with staff and residents. Comprehensive action plans had been developed from these audits and actions were delegated to responsible individuals and were time-bound. However, it was noted that the provider had committed to completing premises works through a compliance plan in 2018. At the time of this inspection, these works were still outstanding. This suggested that while the provider had systems in place to monitor and review the quality of services, the actions arising from these reviews were not always completed in a timely manner. For example, a kitchen refurbishment had been approved in 018 however this work had yet to take place at the time of inspection.

There were clearly defined management structures in place. The centre was managed by a suitably qualified and experience person in charge who was employed on a full-time basis. The person in charge had additional responsibility of another designated centre which was located nearby. There were suitable arrangements in place to support the person in charge of having oversight of the quality and safety of care of both designated centres.

The staffing levels and skill mix were appropriate to the assessed needs of the residents and were in line with the centre's statement of purpose. Relief hours, when required, were provided by existing staff or from a panel of relief staff who were known to residents. This supported continuity of care for residents. A planned and actual roster was maintained by the person in charge.

A training matrix was maintained which demonstrated that staff generally had a high level of both mandatory and refresher training. Staff training records identified that all staff had up-to-date training in fire safety, positive behaviour support, safeguarding and COVID-19. While all staff had completed first aid training, their certificates had expired within the last 12 months and refresher training was required. The need for refresher training had been captured on the provider's training matrix. It was reported by the provider that there were delays in rolling out this training due to current public health restrictions. Supervision arrangements were in place for the person in charge and for staff. Staff meetings were also scheduled on the roster and accurate records of these were maintained.

Registration Regulation 5: Application for registration or renewal of registration

An application to renew the registration of the designated centre was submitted to the Chief Inspector within the required time frame. The application was reviewed and was found to contain full and satisfactory information as set out in Schedule 2 and Schedule 3 of the registration regulations. The prescribed fee accompanied the application form.

Judgment: Compliant

Regulation 14: Persons in charge

There was a suitably qualified and experienced person in charge who was employed in a full-time capacity. The person in charge had oversight of an additional designated centre. There were mechanisms in place to support the person in charge in having oversight of the designated centre in their absence. For example, there was a nominated staff who took a lead role in reporting to the person in charge. The person in charge had allocated administration hours which were divided between the two designated centres. The person in charge had access to their own supervision with the service manager. A review of the supervision records found that these took place regularly and that the content was appropriate to the needs of the person in charge.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual roster was maintained. A review of the rosters found that the staffing levels and skill mix were appropriate to the assessed needs of the residents and were in line with the centre's statement of purpose. Relief staff, when required, were sourced internally. There was evidence that where flexibility in hours were required to support residents' attendance at appointments outside of normal shift hours, that this was facilitated.

Judgment: Compliant

Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that

adequate training levels were maintained. Education and training had been provided to staff which enabled them to provide care that reflected up-to-date, evidence based best practice. Staff required refresher training in first aid. It was reported that staff were wait listed to receive this training however there was a delay in rolling it out due to COVID-19 restrictions. There was clear evidence that staff received supervision as appropriate to their role.

Judgment: Substantially compliant

Regulation 22: Insurance

Proof of a contract of insurance against injury to residents was submitted to the **C**hief **I**nspector as part of the registration application. This was reviewed and was found to be satisfactory.

Judgment: Compliant

Regulation 23: Governance and management

The centre was managed by a suitably qualified and experienced person in charge and was sufficiently resourced to meet the needs of all residents. There was a clearly defined governance structure that facilitated the delivery of good quality care and support that was routinely monitored and evaluated. An annual review had been completed which clearly documented the views of residents in relation to their centre. The report set out an action plan for the centre which took on board residents' feedback. Action plans were comprehensive, time-bound and allocated to a responsible person. Six monthly audits had also been completed by the provider. However, the provider had failed to address known premises issues within the time frame as had been set out in previous compliance plans. The known premises issues contributed to an infection prevention control risk and are set out in more detail under the Quality and Safety section of this report.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place which met the requirements of the regulations. The statement of purpose was available and accessible to residents.

Judgment: Compliant

Quality and safety

Overall, this inspection found that the day-to-day practice within this centre ensured that residents were safe and were receiving a quality service. Some improvements were required to the maintenance of the premises, the arrangements in place for reviewing restrictive practices and to the fire precautions. The inspector also found that, while the designated centre was operating in line with the most recent COVID-19 public health advice, an updated COVID-19 contingency plan was not available for review on the day of inspection.

An up-to-date resident guide was available to residents. This was located in an easily accessible place within the centre. The resident guide was found to contain all of the information as required by the regulations.

There was evidence that residents were provided with appropriate care and support which was cognisant of the residents' abilities, needs and wishes. Residents were supported to access activities, employment and training opportunities as per their interests and needs. Some residents were in employment in the community, while others accessed community courses in areas of interest such as computers, history and astronomy. At the time of inspection, residents were engaged in employment, accessing community courses or attending day services. Most residents accessed a blended model of these activities.

Supports were in place to assist residents in accessing the community independently. Residents showed the inspector that they had the contact details of the nurse manager on call and the emergency services saved in their phones. Where residents had additional health needs, such as epilepsy, there were systems in place to ensure that residents could contact emergency services if required. Technologies required for these systems were paid for by the designated centre. Residents spoke to the inspector about having good personal relationships and links with people in the wider community.

The designated centre was observed to be in need of maintenance including painting and kitchen refurbishment. Small patches of mould were also observed on the bathroom ceiling. These were areas which had been identified as requiring addressing on the previous two inspections. The provider had committed to replacing the kitchen and addressing mould issues in 2018 through a compliance plan. The person in charge informed the inspector that a kitchen refurbishment was planned for October 2021. Evidence of this plan was reflected in the provider's annual review. However this work had not commenced at the time of inspection.

Residents had access to a large back garden. This garden was in need of general maintenance including grass cutting and external windowsill repainting. Residents also expressed a wish for a covered area in order to facilitate smoking access in bad

weather. Several windows in the designated centre required maintenance. One living room window did not close fully and presented a security risk. The provider took measures to address this on the day of inspection. Other window handles were loose however the windows could be closed and secured. A window in a resident's bedroom was observed to have a gap even when fully closed. A draught could be felt and traffic outside could be clearly heard through this gap. This resident informed the inspector that their bedroom can be cold at night time. Some residents were in the process of refurbishing their bedrooms in line with their personal tastes and were happy with the work that had been completed.

Risk management procedures were in place including an up-to-date risk management policy, an active local risk register and a local accident and incident log. Health and safety checklists were completed monthly for the designated centre. Risk assessments for individual risks had been completed and were available on resident files. Arrangements that were in place to control for risks appeared to be proportionate to the risk identified and the impact on the resident's quality of life had been considered. For example, there was evidence that the risk of residents independently accessing the community in the evenings when the house was unstaffed had been assessed. Control measures had been implemented to mitigate against the known risks. Staff and residents spoken with were knowledgeable as to the risks and to the control measures that were in place. Residents spoken with were in agreement with the control measures that were in place which impacted on them.

There were procedures in place to reduce the risk of healthcare associated infections in the designated centre. A daily cleaning checklist was maintained. The kitchen appliances and countertops were observed to be clean. However, the kitchen cabinets presented a risk to infection prevention and control. The laminate cover on kitchen presses was observed to be peeling, making it difficult for staff to ensure the kitchen was thoroughly clean. Staff were observed adhering to standard precautions including wearing face masks and maintaining physical distancing where possible. There were precautions in place in order to mitigate against the risk of a COVID-19 outbreak in the centre. For example, all staff had completed COVID-19 training, visitor temperature checks were completed and records were kept of contact details of visitors. Individualised isolation plans were in place for each resident in the event of them contracting COVID-19. However, an updated COVID-19 contingency plan was not available on the day of inspection.

The registered provider had taken precautions against the risk of fire in the designated centre and had made adequate arrangements for maintaining fire equipment and detecting, containing and extinguishing fires. Self-closing mechanisms were observed on all doors within the designated centre. Personal evacuation plans were in place for all residents and were up-to-date. A night-time and day-time fire drill had taken place within the last 12 months and on both occasions all residents evacuated safely in an appropriate time. Learning from fire drills was clearly documented and actioned. A risk was identified by the inspector in relation to the front door which was noted to have three locks. One was a chubb lock which could be opened without a key. The other two locks could be secured internally or externally with a key. A copy of this key was kept in an emergency

access box inside the house. It was unclear on the day of inspection who had access to additional copies of this key with residents reportedly mainly using the chubb lock. Without knowledge of who had copies of this key, there was the potential that the front door and primary means of fire escape could be triple locked at night-time. This would result in a delay to residents evacuating from the building.

A review of resident files demonstrated that comprehensive assessments of need had been completed and that these had been updated within the last 12 months. Support plans were in place for identified needs. These support plans were written in a person-centred manner which accounted for residents' personal wishes and preferences. Support plans included measures to respect residents' autonomy. Personal planning review meetings had taken place in the last 12 months and goals had been identified from these for each resident. A goal tracker was in place to track progress towards achieving these goals. Health care plans were in place for each assessed need. There was evidence that residents had access to a range of multi-disciplinary professionals as required including access to general practitioners, dentists, chiropody, psychology and neurology. There was evidence that residents had been supported to attend virtual MDT clinics during COVID-19 restrictions when face-to-face appointments were suspended.

Communication plans took into account any communication needs which residents had including literacy difficulties. There was evidence that staff in the designated centre took measures to ensure that information was available to residents in an accessible manner. For example, a visual menu board, visual staff roster and individualised daily schedules were available. Residents had been supported to access assistive technology to promote their full capabilities including applications on their phones and a tablet device for the centre. Residents spoke about how this technology was supporting their independence.

The inspector found that there was a support arrangement in place in relation to residents' use of alcohol and cigarettes that was restrictive in nature. While this restrictive practice had been implemented with the informed consent of residents, it had not been recognised as a restrictive practice and had not been applied in line with the provider's own policy. The provider was required to review these support plans and the potential for them to impact on residents' rights.

The provider had ensured that there were systems in place to safeguard residents from potential abuse. All staff had completed safeguarding training. Staff spoken with were knowledgeable regarding safeguarding risks and were aware of their roles and responsibilities in reporting safeguarding concerns. Up-to-date policies in relation to safeguarding and intimate care were in place in the centre. Where safeguarding concerns had been identified the correct procedures had been followed in notifying relevant authorities.

Regulation 10: Communication

The registered provider ensured that residents were assisted and supported to communicate in accordance with their needs and wishes. Individual communication supports were detailed in residents' personal plans. These were written in a respectful manner. Residents had access to appropriate media including house telephone, their own mobile phones and internet access. Residents were supported to use other assistive technologies including applications on mobile phones and a computer tablet to promote their full capabilities.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were provided with appropriate care and support which recognised their individual abilities, needs and wishes. The registered provider had ensured that residents had access to facilities for occupation, employment and recreation. Residents were supported to participate in activities which were in accordance with their interests and capabilities. Residents accessed a variety of in-house and external activities which included astronomy, cooking, computers, independent living skills, gardening and history and geography classes. Where there was a risk to residents in accessing the community independently, this had been risk assessed and measures had been implemented to mitigate against the risk. Residents were supported by various technologies and communication supports to support their independence. Residents described having good personal relationships and links with their wider community.

Judgment: Compliant

Regulation 17: Premises

The premises was observed to be generally clean and tidy however it was in need of general maintenance and repairs. A maintenance log demonstrated that maintenance requests had not been completed in a timely manner. The provider had also committed to completing premises works through a compliance plan in 2018. At the time of inspection these works had not been completed. The premises areas which required addressing including:

- kitchen upgrade - the inspector was informed that this is due to commence in the coming weeks
- painting in the kitchen and hall, stairs and landing
- there was mould in the kitchen and bathroom
- general back garden maintenance
- window handles were in need of repair

- one window did not fit securely and presented a security risk. Measures were taken by the provider to address this on the day of inspection
- a window in a resident's bedroom did not fit tightly and a draught could be felt coming in through the window.

Judgment: Not compliant

Regulation 20: Information for residents

An up-to-date resident guide was available to residents. This guide was written in an accessible manner and contained all of the information as required by the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

A risk management policy was in place. Risk assessments were in place for identified risks. The impact of measures to mitigate against risks on individual's rights and autonomy had been considered and had been discussed with residents.

Judgment: Compliant

Regulation 27: Protection against infection

Standard precautions were in place in order to reduce the risk of residents contracting a health-care associated infection. However, improvements were required to the premises, in particular to the kitchen in order to ensure that all surfaces were easy to clean and sanitise.

It was clear that the designated centre had measures in place in relation to mitigating against the risk of COVID-19. These measures had been risk assessed and were found to be in line with current public health guidance. However an updated COVID-19 contingency plan for the centre was not available on the day of inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had arrangements in place against the risk of fire. There were adequate arrangements for detecting, containing and extinguishing fires, giving warning of fires and evacuating all individuals. Personal evacuation plans were in place for all residents. Fire drills had been completed in line with the provider's policy and all residents had evacuated in a safe timeframe. Learning from these drills was documented.

Fire equipment was noted to have been recently serviced. Self-closing mechanisms were observed on all doors in the premises. Several of these were tested on the day of inspection and were observed to operate as designed. All staff had up-to-date fire training. Residents spoken with were aware of the procedures to be followed in the event of a fire alarm sounding.

A risk was identified on the day of inspection in relation to the locking of the front door. There was the potential for this door to be triple locked and while residents could access an emergency key located in a box inside the front door, this had not been practiced in fire drills. It was unclear who had copies of this key and the circumstances, if any, when it may be used to triple lock the door. The provider is required to take measures to address this risk. This risk is compounded by the fact that the house is unstaffed at night time.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of need had been completed for residents. These had been reviewed within the last 12 months. Resident files documented support from clinical professionals as required.

Judgment: Compliant

Regulation 6: Health care

Residents had access to a range of multi-disciplinary professionals as required based on their assessed needs. Comprehensive care plans were in place and were up to date for each assessed need.

Judgment: Compliant

Regulation 8: Protection

All staff had up-to-date safeguarding training. Staff spoken with demonstrated an understanding of safeguarding and the processes to report concerns. Safeguarding concerns had been notified to the relevant authorities as required. Policies in relation to intimate care and safeguarding were in place and were up to date.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector found that there was a support arrangement in place in relation to residents' use of alcohol and cigarettes that was restrictive in nature. While this restrictive practice had been implemented with the informed consent of residents, it had not been recognised as a restrictive practice and had not been applied in line with the provider's own policy. The provider is required to review these support plans and the potential for them to impact on residents' rights.

Judgment: Not 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	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 8: Protection	Compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for B Bettystown Avenue OSV-0002364

Inspection ID: MON-0026536

Date of inspection: 28/09/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • 1 staff is scheduled to receive first aid refresher training on 25/11/21. • 1 staff is scheduled to receive first aid refresher training on 08/12/21 • Remaining 2 staff are scheduled to complete first aid refresher training by 31/01/2022	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Actions outstanding relating to premises from previous inspections have now been either completed or scheduled to be completed. Going forward all actions will be addressed in a reasonable time frame.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Kitchen upgrade was completed as of 27/10/2021 • painting in the kitchen and hall, stairs and landing. Scheduled to be painted by 30/06/2022 • Mould has been cleaned as per SMH Environmental Hygiene & cleaning guidleines as of 1/11/21. They are scheduled to be repainted by 30/06/2022	

• TSD due to carry out garden maintenance by 30/11/21 • Contractor scheduled to replace window handles by 30/11/21 • Contracters are scheduled to repair windows by 30/11/21

Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • Covid 19 contingency plan has been reviewed and updated to reflect all current guidelines and protection controls and is in place as of 01/11/21	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Locks on front door was reviewed by PIC & SMH Fire Officer. It was decided that the additional locks that were in place on day of inspection were not necessary and were removed as of 1/11/2021. All residents can now exit safely using thumb turn locks on front door.	

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Discussion was had with resident around supports with using cigarettes and alcohol. Resident decided that they would keep these in their own room as of 06/10/21. Resident will link in with staff if further support in managing these items is needed. Going forward any supports that may restrict residents access to property in any way will be in line with SMH restrictive Practice policy and will be reviewed by SMH Positive Approaches Monitoring Group before being implemented. All restrictive practices will be recorded on the centre's restrictive practice log. • All related risk assessments have been reviewed as of 03/11/21	

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	31/01/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2022
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in	Not Compliant	Orange	30/11/2021

	good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
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 to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/11/2021
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	01/11/2021
Regulation	The registered	Substantially	Yellow	01/11/2021

28(2)(b)(i)	provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Compliant		
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	06/10/2021