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:	Marley Court
Name of provider:	St Michael's House
Address of centre:	Dublin 14
Type of inspection:	Announced
Date of inspection:	02 September 2021
Centre ID:	OSV-0002402
Fieldwork ID:	MON-0026224

About the designated centre

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

Marley Court is designated centre operated by St. Michael's House. The centre comprises a six bedroom, two storey house, located in a busy South Dublin suburb. The designated centre is located in close proximity to a large shopping centre, restaurants, wooded areas, and other amenities. Marley Court designated centre provides residential care and support to six adults with intellectual disabilities, and can support residents who have additional physical or sensory support needs. The centre is managed by a person in charge and person participating in management as part of the provider's governance oversight arrangement for the centre. The centre is staffed by a team of social care workers.

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 - 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
Thursday 2 September 2021	10:30hrs to 16:45hrs	Maureen Burns Rees	Lead
Thursday 2 September 2021	10:30hrs to 16:45hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

Inspectors had the opportunity to meet with most residents on the day of inspection. Some residents chose to speak to the inspectors in more detail about their experiences of living in their house. Other residents did not wish to speak to the inspectors and their wishes were respected.

Several family members of residents had completed feedback questionnaires which were made available to the inspectors. Inspectors used conversations with residents and key staff, resident questionnaires, observations and a review of documentation to inform judgments on the quality of care in the designated centre.

Inspectors wore personal protective equipment (PPE) and maintained social distancing whilst in the house in line with public health guidance. Overall inspectors found that residents were happy with the quality of care that they were receiving in their home. Residents spoke highly of the staff support available to them. One resident told inspectors that the staff are nice and make residents laugh. Family members also complimented the staff team, describing staff as "kind" and "hard-working".

Staff and resident interactions were observed to be friendly and warm. Several staff were observed using gestures and sign language in order to support their communication with residents who required such support. Visual supports such as a visual staff roster and choice boards such as menu choices were also observed throughout the designated centre. Staff could explain how they use these visual supports to assist residents in decision making regarding the running of their home.

Residents were observed coming and going from their home freely and accessing various parts of their home. All residents had returned to day service on a part-time basis. On the day of inspection, some residents were out at day service while others were observed to take part in activities within their home including an online chair yoga class, puzzles, talking to family members on Ipads and listening to music. Another resident went for a walk independently. One resident showed inspectors their "all about me" plan and appeared proud of this. Another resident showed inspectors that they had a fridge in their room to store their own drinks and told inspectors that this was important for them. The designated centre was decorated with residents' artwork and photographs throughout.

On the day of inspection, residents were preparing to go on a holiday together to one of the provider's respite houses. This had been planned to facilitate painting works in the designated centre. Several residents were observed accessing the utility to do their own laundry whilst others availed of staff support to pack their clothes. One resident informed inspectors that they were looking forward to the holiday.

While residents and family members appeared to be happy with the quality of care

received within the designated centre, they expressed concerns regarding the house facilities. Inspectors observed that while the house was generally clean and tidy, the premises itself was in a state of disrepair and in need of refurbishment.

The provider had undertaken, through an urgent compliance plan, to complete several upgrade works to the premises by end of October 2021. At the time of inspection, inspectors found that some of these works had been completed however many other works were outstanding. This will be discussed in more detail under the Quality and Safety section of this report.

Residents, family members and staff spoke about the impact of the premises on the residents. They explained that, in spite of daily cleaning, there were ongoing issues with mould on the bedroom windows and walls. Some residents have diagnosed respiratory conditions. Other residents were unable to fully access their back garden due to uneven paths and overhanging branches. The kitchen was noted to be in a general state of disrepair with missing cupboard doors, drawers which did not run smoothly on rails and swollen internal dividers inside cupboards. This made it difficult for residents to use the kitchen and for staff to ensure a clean and sanitary food preparation environment.

Overall, the inspectors found that residents were happy with the quality of care that they received in their home. However, the poor state of repair of the premises was found to be having an impact on residents' health and well being and their right to freely access and use all areas of their home.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The inspectors were not satisfied that the governance and management systems were effective in responding to known quality and safety risks.

The provider had submitted a compliance plan which set out measures to address urgent risks in relation to the premises of the designated centre. Inspectors found that while some of the actions had been completed, for example laying new flooring on the ground floor, other works had either not been completed or were not functioning in order to meet residents' assessed needs. For example, the upstairs bathroom had been reconfigured into a wet room however the drain was not functioning correctly. This led to pooling of water on the floor of the bathroom and outside on the hallway.

Additionally, a clinician's report had identified that the shower room was too small to install grab rails. This was identified by the person in charge as a falls risk. Inspectors saw evidence that this risk had been escalated through senior

management. Attempts had been made to re-lay the bathroom floor however it was still inadequate in meeting the drainage requirements of the shower. Other works were outstanding including painting, treatment and management of mould and energy efficiency works.

An annual report and six monthly reviews of the quality and safety of care had been completed by the provider. The annual report involved consultation with residents and documented residents' concerns regarding the showers and the windows in the designated centre. A hygiene audit had also been completed in January 2021 by the provider which identified several outstanding issues in relation to the premises.

Plans had been put in place in order to address the issues identified in these reports however these plans had not been actioned in a timely manner. A review of the records showed that the person in charge had consistently raised safety issues through the lines of management. These issues had not been satisfactorily addressed by the provider at the time of inspection. It was not clear in the provider's reports who had authority and accountability for progressing the works to be completed in their action plans

The designated centre was found to be staffed by a suitably qualified and experience person in charge. The person in charge was full time with sole responsibility for this designated centre. The person in charge demonstrated good knowledge of their regulatory requirements and were open and transparent in their dealing with the inspector regarding non-compliances in the designated centre.

There was a full complement of staff in place which was in line with the designated centre's statement of purpose. The majority of staff had worked in the current designated centre for several years which ensured consistency for residents. Actual and planned rosters were maintained in line with the regulations.

A review of training records identified that several staff were overdue refresher training in mandatory training areas including fire safety, manual handling, safe administration of medications (SAMs) and positive behaviour support. There were suitable staff supervision arrangements in place which were in line with the provider's supervision policy. Two staff who were spoken with felt that they were adequately supported and supervised in their role.

An incident and accident log was maintained within the designated centre. Generally there were found to be very low levels of incidents within the designated centre. A review of the incident log identified one allegation of peer to peer abuse which had not been notified to the chief inspector in accordance with the regulations. Other incidents reviewed were found to have been notified accordingly.

Regulation 14: Persons in charge

The designated centre was found to be run by a suitably qualified and experienced person in charge. The person in charge was full-time and had sole responsibility for

the current designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing was found to be in line with the designated centre's statement of purpose. Staffing levels were found to be appropriate to meet the assessed needs of residents. There was continuity of staffing which enhanced consistency of support for residents.

Judgment: Compliant

Regulation 16: Training and staff development

There were suitable staff supervision arrangements in place which were in line with the provider's supervision policy. However, several staff were overdue mandatory training including in the areas of fire safety, SAMs, manual handling and positive behaviour support.

Judgment: Not compliant

Regulation 23: Governance and management

The inspectors were not assured that effective management systems were in place to ensure that the service provided was safe, appropriate to residents' needs and consistently and effectively monitored.

Annual and six monthly reports had been prepared however the plans arising from these had not been effective in addressing concerns regarding the standard of care and support within the designated centre in a timely manner.

Action plans also failed to identify the lines of authority for progressing the agreed actions.

Judgment: Not compliant

Regulation 31: Notification of incidents

A local log of accidents and incidents was maintained. Generally there were a low level of accidents and incidents within the designated centre. Inspectors found one incident of peer to peer abuse which had not been notified to the chief inspector in line with the regulations.

Judgment: Substantially compliant

Quality and safety

Inspectors found that residents were generally happy with the care and support which they were receiving from the staff within the designated centre. Residents' health care and behaviour support needs were being appropriately managed. However, inspectors identified there were long-standing premises issues which had not been addressed in a timely manner by the provider. The premises issues were found to be having a significant impact on the quality of residents' lives and the safety of the service.

Inspectors observed windows in residents bedrooms had not been replaced as had been set out in the provider's urgent compliance plan. A daily cleaning protocol had been implemented. This had been effective in substantially reducing the amount of mould which was evident in bedrooms.

However, in spite of this, patches of damp and mould were observed in the corners of windows and on the walls in residents bedrooms. One resident showed the inspectors how they could not open their bedroom window as it was too stiff for them to manage. This resident expressed frustration regarding the ongoing premises issues. The upstairs bathroom had been reconfigured into a shower room with PVC walls. This had been effective in reducing mould. However, staff and residents reported that the shower room was difficult to use and that it regularly flooded to the hall outside. This presented a falls risk to residents.

The kitchen in the designated centre was found to be unsuitable to meet residents' needs. The kitchen was in a state of disrepair and had been identified in the provider's own hygiene audit as presenting a risk to infection prevention and control. There was a door missing from a corner press, drawers were observed to not run smoothly on castors, a smell was noted coming from the kitchen sink and shelves underneath the sink were noted to be rotting and swelling. The microwave was also broken on the day of inspection.

Several other areas of the designated centre required maintenance. These had been documented in the provider's hygiene audit which had been completed in January 2021. They included repairing the floor in the utility room which had peeled away in one corner and painting throughout the designated centre.

There was evidence that the garden of the designated centre had been previously

landscaped with paths and flower beds throughout the garden. One resident proudly showed the inspectors a planter and plants that they were growing. There was evidence that residents enjoyed the garden with bird feeders and ornaments decorating the flower beds. However, inspectors noted the garden had fallen into disrepair.

Staff reported that it was difficult for some residents to access their garden as the paths were uneven and branches obstructed the paths. Inspectors walked the path on the day of inspection and could not walk around the garden without walking in gravel beds. This would not be possible for some residents who used walking aids. On the day of inspection, a foul smell was noted to be coming from the shore underneath the kitchen window. There was pooling of murky water on the concrete outside the kitchen window. This was felt by inspectors to be contributing to the smell inside the kitchen. The provider's maintenance department took action on the day of inspection in order to clear the shore.

There was an up-to-date risk management policy and a risk register in place within the designated centre. Risk assessments had been carried out for all identified risks and the measures which had been implemented to mitigate against risks were found to be proportional. The risk register was found to be reflective of the level of risk within the designated centre. For example, the risk to residents with respiratory conditions sleeping in bedrooms with mould was risk rated "red".

The provider had adopted a range of infection prevention and control procedures to protect resident from acquiring a health care associated infection. Cleaning schedules and rotas were in place. A COVID-19 contingency plan was in place for the designated centre with clear processes set out. Inspectors observed staff cleaning high traffic areas during the course of the inspection. Inspectors observed staff wearing appropriate PPE and maintaining social distancing where possible. The provider had completed a hygiene audit in January 2021 which identified several areas for improvement. These areas were generally in relation to premises refurbishments.

There was evidence that effective fire safety management systems were in place in the designated centre with adequate arrangements for the prevention, detection and containment of fires. Fire drills had been completed in line with the provider's fire safety policy and residents had evacuated within a safe time-frame during a recent night-time drill. Staff spoken with were knowledgeable regarding the fire panel and fire evacuation procedures. Personal evacuation plans were in place for residents. A gate in the back garden presented a fire risk. The gate could only be opened from inside the back garden and the bolt on the gate was observed to be rusting and stiff. When inspectors attempted to open the gate they found that it was fixed too close to the ground and did not swing open freely. This was found by inspectors to present a risk to residents evacuating through the back garden in a safe and timely manner.

Inspectors reviewed the practices in relation to medicines and pharmaceutical services within the designated centres. Inspectors found evidence that the ordering, disposal and administration of medications were in line with the regulations. There

were systems in place for recording, responding and learning from medication administration errors. Staff spoken with were clear on the procedures to be followed should a medication error occur. Staff spoken with were also clear on the process to be followed in relation to the administration of controlled medications.

One medication, a thickener for thickening fluids, was not stored securely and an immediate action was issued to the person in charge. The thickener was moved to the locked medications press on the day of inspection. While some resident files detailed that residents did not wish to self-administer their own medications, risk assessments and assessments of capacity to take responsibility for their own medications were not available on all resident files.

Inspectors reviewed a sample of resident files. Inspectors found that a comprehensive assessment of need had been completed for each resident with a range of comprehensive support plans completed for identified areas of need. There was evidence that residents' healthcare needs were being appropriately met. Several residents spoke positively to inspectors regarding the supports they received from staff to maintain a healthy lifestyle.

Inspectors reviewed positive behaviour support plans and found that these were in place and were up to date for those residents who required them. Environmental strategies such as staggered mealtimes had been implemented to good effect in order to reduce behaviours that challenged at these times. Staff spoken with were knowledgeable regarding residents' behaviour support plans.

There were no safeguarding concerns at the time of the inspection. Inspectors found that an up-to-date safeguarding plan was in place for one resident who required this. An up-to-date policy and procedure for safeguarding adults was also available in the designated centre. Staff spoken with were aware of who the designated officer was. These staff were knowledgeable regarding recognising signs of abuse and of how to report their concerns should they have any. Intimate care plans of sufficient detail were in place and were up to date for those residents who required them.

Regulation 17: Premises

The provider had committed through an urgent compliance plan to complete essential premises work by the end of October 2021. At the time of inspection, only some of these works had been completed with many others outstanding. Some of the works which had been completed were not to an appropriate standard to meet the needs of the residents. The designated centre was found to be in a poor state of repair both internally and externally. The facilities within the designated centre were found to not have been maintained in good working order. The provider has failed to take timely action to address long-standing and known premises issues. These issues included:

- Windows had not been upgraded. Single glazed windows were draughty and

contributed to damp issues in bedrooms. One resident was unable to open their window as it was too stiff for them to manage.

- Wall insulation had not been upgraded. Mould and damp patches were present in residents' bedrooms.
- Residents were unable to fully access their back garden as the paths were uneven and the trees obstructed access.
- Drainage issues were evident with a foul smell being noted near the kitchen sink. Pooling of murky water was observed at the shore outside the kitchen window.
- The kitchen was in a poor state of repair with missing cupboard doors, a broken microwave and rotten and swollen dividers inside cupboards.
- A section of tiling was missing behind the kitchen cooker which led to build up of grime and presented an infection control risk.
- The shower room floor did not drain efficiently. This was reported to lead to flooding which reached as far as the hallway on the upstairs landing.
- The toilets downstairs required repainting.
- The floor in the utility had come up in one large piece in a corner. This had been noted in the provider's own hygiene audit.

Judgment: Not compliant

Regulation 26: Risk management procedures

An up to date risk management policy was in place for the designated centre. There were systems in place to allow for the assessment, management and ongoing review of risk within the designated centre. The risk control measures were found to be proportional to the risk identified and the impact of risk control measures on residents' quality of life was considered.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had adopted procedures to protect residents from acquiring a healthcare associated infection. Staff were observed using PPE, following good hand hygiene practices and maintaining social distancing where possible and appropriate. An up-to-date self assessment of preparedness for COVID-19 had been completed by the provider. A hygiene audit in January 2021 by the provider identified premises issues as an infection prevention and control risk. Several of these premises issues were outstanding at the time of inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Inspectors found that there were effective fire safety management systems in place. There were adequate arrangements for the prevention, detection and containment of fires. Staff spoken with were knowledgeable regarding fire evacuation procedures. Some staff required refresher training in fire safety. Fire drills were carried out in line with the provider's fire safety policy. Whilst two residents could evacuate out a front door or a back door, it was found that if they were to evacuate out a back door they may be impeded by being unable to open the side gate. This was due to the poor state of repair of the gate and bolt. Staff spoken with expressed concern that they would be unable to assist residents as the gate could not be opened from the front garden.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that the procedures in place for the ordering, storing and administering of medications were generally in line with the regulations. One medication was observed to not be stored securely and an immediate action was issued on the day of the inspection. While some resident files documented residents' choices in relation to self-administering of medications, risk assessments and assessments of capacity to take responsibility for medications were not available on all resident files.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed a sample of individual resident files. Inspectors found that there was a comprehensive assessment of needs completed for each resident which was used to inform a range of support plans. There was evidence that individualised goals had been set. Some of these goals had been carried from 2020 as they had been hindered by the national restrictions. A My Life meeting or All about Me review had been completed with each resident within the last 12 months.

Judgment: Compliant

Regulation 6: Health care

Inspectors reviewed a sample fo residents' healthcare plans and found evidence that residents' assessed healthcare needs were being met. There were detailed health plans on file for residents requiring these. Some residents spoke to inspectors positively regarding the supports that they had received to lose weight and to maintain a healthy lifestyle.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were up-to-date positive behaviour support plans in place for residents who required these. Staff spoken with were aware of the behaviour support needs of residents. There were no restrictions within the designated centre and generally there appeared to be low levels of behaviour that challenges within the centre.

Judgment: Compliant

Regulation 8: Protection

There were no safeguarding concerns documented within the designated centre in the preceding 12 months. A safeguarding plan was in place for one resident who required this. Staff spoken with were aware of safeguarding arrangements. Intimate care plans were uo-to-date fo residents who required these.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially 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	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Marley Court OSV-0002402

Inspection ID: MON-0026224

Date of inspection: 02/09/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training plan developed and prioritized. • SAM training completed by all staff by 15.09.2021 • Fire Safety training: 3 staff required refresher training. 2 staff will complete the training on the 07.10.2021. 1 staff will complete the training on the 11.10.2021 • Manual Handling refresher training 2 staff to complete. 2 staff scheduled to complete the training on the 07.10.2021. Risk assessment is in place. • Positive Behaviour Support refresher training 2 staff to complete refresher training on 07.10.2021.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In response to the area of non-compliance found under Regulation 23(1) (b) • The Registered Provider has a full time Person in Charge in the centre. The PIC is aware of their lines of authority and accountability and specific responsibilities' for all areas of service provision and is supported by the centres Service Manager (PPIM) and the Director of Adult Services (PPIM) in implementing all areas of responsibility. • The Director of Adult Services established a governance and management panel to oversee all the identified works required in the centre. The Panel consists of the PIC,	

Service Manager, Director of Operations, SMH Housing Manager, SMH Head of Technical Services and the Director for Adults Services. The panel will ensure all actions from the recent HIQA inspections and internal audits/reviews are supported and implemented within the agreed timeframe.

- In response to the area of non-compliance found under Regulation 23(1)(c)

The Director of Adult Services and the Service Manager will support the PIC in implementing efficient and effective management systems into the centre to ensure the service that is provided is safe, appropriate to the residents' needs and monitored regularly.

The PIC and Service Manager have Monthly Data reports in place in the centre and all agreed actions from HIQA inspections and internal reviews/audits will be discussed during their supervision meetings.

The PIC also has a Quality Enhancement Plan (QEP) in place in the centre, which will capture all agreed actions from inspections. The QEP will be updated quarterly and all agreed actions from the HIQA inspections and internal audits/ reviews will inform this document and will be monitored regularly by the PIC and Service Manager.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
- PSF1 completed 29.09.2021 and NF06 completed 01.10.2021 retrospectively.

The PIC will ensure that all required notifications will be sent to the authority in the required timeframe.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to regulation 17(1)(b).

- Representatives of the registered provider Technical Service Department and SMH Housing Association visited the centre on the 15.9.2021 and the 16.9.2021 respectively to review the premises and outline works that are required to keep the centre in good repair externally and internally.

- SMH Housing Association Manager updated the Governance and Management panel on the 17.9.2021 of areas for repair and improvement and will inform the schedule of works for the centre.

In response to regulation 17(4)

- Meeting was held on the 15.09.2021 with the Housing Association, SMH Director of Operations, SMH Technical Service Manager, SMH Director of Service and the Service Manager to schedule plan of works required for the designated centre.

The agreed plan is as follows

1. New Double glazed Windows to be installed throughout the house.
New Air to water heating System.
New Wall insulation of external wrap around and cavity wall insulation.
Upgrade of extraction systems to wet areas.

2. High trees require topping and will be completed by the 13.10.2021.

3. Shrubs pruned back tight, with all debris removed to allow access. This was completed on the 24.09.2021

4. Gravel has spread onto paved area and needed to be tidied. This was completed 24.09.2021.

5. Paving track around garden to be widened as per OT report/recommendation and any uneven section to be levelled. TSD will source contractors to complete the works by 31.12.2021

6. Immediate works in kitchen, level tiles behind the cooker and re grout. Repair the door that is off cupboard under sink completed on the 04.10.2021.

7. Kitchen unit to be replaced. Quotes for replacement kitchen are currently being sought, 1 quote received and 2 more pending. Funding will be required from Housing Association Board for approval of works. Kitchen replacement to be completed 31.01.2022

8. Shower cubicle was installed with low tray completed on 12.09.2021. Hand rails ordered and fitted on the 04.10.2021.

9. Areas for painting kitchen, dining room, downstairs bathroom, hall stairs & landing including all doors / architraves downstairs, banisters will be completed by the 30.12.2021. Any rooms with evidence of mould will be treated and painted by 15.10.2021.

10. The flooring in the utility was replaced on 04.10.202

11. New microwave was puchased but incorrect delivery which was there on the day of inspection. This was rectified and new microwave in unit on 09.09.2021.

In response to regulation 17(7)

• The Service Manager will complete a 6 monthly audit of the centre which will include schedule 6 as part of their review of the centre.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: 1. New Double glazed Windows to be installed throughout the house. New Air to water heating System. New Wall insulation, a combination of external wrap around or cavity pumped or dry lining will be installed and attic insulation to a minimum of 300mm depth. Upgrade of extraction systems to wet areas. Works starting 25.10.2021 and will be completed 08.11.2021. Professional cleaners will provide a deep clean immediately after works completed 2. Level tiles behind the cooker and re grout. Repair the door that is off cupboard under sink was completed by the 04.10.2021. 3. Kitchen unit to be replaced. Quotes for replacement kitchen are currently being sought, 1 quote received, 2 quotes pending. Funding will be required from Housing Association Board for approval of works. Kitchen replacement to be completed 31.01.2022 4. Rooms with evidence of mould will be treated and painted by 15.10.2021 5. The flooring in the utility was replaced on 04.10.2021.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Gate assessed by technical services department and fixed on 04.10.2021. • Long term plan to replace the side gate. Quotes are being sought in line with procurement process. Contractor will complete installation of new gate by 31.12.2021	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • Storage of medication identified on day of inspection has been addressed this medication is now stored securely and in line with regulation. • Assessment of capacity completed 29.09.2021 and available in relevant file. Support plans completed for each resident 29.09.2021.	

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.	Not Compliant	Orange	30/10/2021
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	Red	31/01/2022
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	Red	31/01/2022

	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 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Red	30/11/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	31/01/2022
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.	Not Compliant	Orange	05/10/2021
Regulation 27	The registered	Substantially	Yellow	31/01/2022

	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.	Compliant		
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/12/2021
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	05/10/2021
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and	Not Compliant	Orange	05/10/2021

	assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Substantially Compliant	Yellow	05/10/2021