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

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| Name of designated centre: | Cairdeas |
| Name of provider: | RehabCare |
| Address of centre: | Limerick |
| Type of inspection: | Unannounced |
| Date of inspection: | 29 July 2021 |
| Centre ID: | OSV-0002651 |
| Fieldwork ID: | MON-0033675 |

## About the designated centre

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

This designated centre provides a respite service for persons with a physical or sensory disability; a maximum of six persons can be accommodated at any one time. The premises are purpose built on a campus operated by the provider where other unrelated services are provided. The centre is a relatively short commute from the city and transport is provided. Each resident has their own bedroom for the duration of the respite stay; bathrooms are shared between two residents. The service is funded to open 261 nights per year and the opening times and the duration of the respite stay can vary according to individual requirements. When open the service is staffed on a 24 hour basis and the staff team is comprised of care workers, support workers and nursing staff. The service is described however as based on the social model care of care; nursing input is provided to meet day to day needs but not higher needs that require a full-time nursing presence.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 2 |

## 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 29 July 2021 | 9:25 am to 5:15 pm | Caitriona Twomey | Lead |

## What residents told us and what inspectors observed

This designated centre provides a respite service for persons with a physical or sensory disability; a maximum of six persons can be accommodated at any one time. The premises are purpose built on a campus operated by the provider where other unrelated services are provided. The centre is a relatively short commute from the city and transport is provided. Each resident has their own bedroom for the duration of the respite stay; bathrooms are shared between two residents. The service is funded to open 261 nights per year and the opening times and the duration of the respite stay can vary according to individual requirements. When open the service is staffed on a 24 hour basis and the staff team is comprised of care workers, support workers and nursing staff. The service is described however as based on the social model care of care; nursing input is provided to meet day to day needs but not higher needs that require a full-time nursing presence. Overall, residents had positive experiences when staying in this centre and received a high quality service. This was clearly communicated to the inspector by the residents they met with and was also the overall theme of the feedback from residents recorded at the end of their visits. The service provided was tailored to the needs and preferences of whoever was staying in the centre at the time by a dedicated staff team. Some improvements were required in the oversight and monitoring of the service provided to ensure that the high quality was maintained and to drive service improvement.

On arrival, the inspector met with a member of the staff team. Enhanced infection prevention and control procedures and protocols were in place due to the ongoing COVID-19 pandemic. The staff team and the inspector adhered to these throughout the day. The centre had closed for over three months in response to the pandemic and had re-opened in July 2020. The centre's registration allowed six people to stay in the centre at any one time. As part of the protocols in place, the centre was operating at a reduced capacity. The most recent statement of purpose (a document that the provider is required to prepare that describes the purpose and function of the designated centre) stated that a maximum of four people could stay at any one time. On the day of inspection, there were two residents in the centre who were leaving the following day after a four-night stay. As well as reducing the number of people who stayed in the centre, the use of some rooms had also changed. For example, a room that was previously a resident's bedroom was now a staff office. The inspector requested that an updated floor plan be submitted to HIQA (Health Information and Quality Authority). It was also discussed that at one time during the pandemic the centre had been used to support someone who needed to isolate, after a hospital stay, before they could return to their residential service. As management advised that this could happen again, the inspector asked that this be reflected in the centre's statement of purpose, and to include the management and oversight arrangements for the support provided to any resident using the centre for isolation purposes.

The inspector met with both of the residents staying in the centre at the time of the

inspection. Both had stayed in the centre before, with one visiting annually and the other staying several times a year. When talking about the centre, both residents highlighted how much they appreciated the staff working there. It was a clear source of comfort that they met the same staff during their visits, a number of whom had worked there for over 15 years. The style and approach of the staff was also mentioned with residents describing their approach as helpful, kind and friendly. This was observed first-hand on the day of inspection and it was clear that staff knew the residents and their support needs well. Residents spoke to the inspector about small adjustments that staff had made that had made a big difference to their enjoyment of their stays and described how staff gave the impression that nothing was too much trouble.

It was clear to the inspector that the needs and preferences of the residents were central to how support was provided. When the inspector arrived, both residents were asleep and staff worked in such a way so as not to disturb them. Warm, respectful interactions were also observed and heard regarding entering residents' bedrooms, plans for the day, and facilitating the inspector to meet with the residents. The activities that residents had participated in were aligned to their interests and residents spoke positively about trips to the cinema and a shopping centre that they had enjoyed. It was made clear that neither resident would ordinarily have the opportunity to take part in such outings while at home. This made their stay all the more enjoyable and meaningful for them. One resident spoke about their initial apprehension before their first visit to the centre but that those feelings had been quickly allayed on their first night. They told the inspector that they would fully recommend the centre to someone in a similar position to themselves.

Both residents were universally positive in speaking about the centre and had never had cause to complain. If such a need were to arise, both residents said they would be comfortable in doing so and were assured that any matter would be addressed. While there was evidence to support the quick resolution of most complaints made in the centre, there were areas of improvement identified regarding the implementation of the provider's complaints policy. This will be discussed in more detail later in the report in the capacity and capability section.

The centre was purpose built in 2001 with the needs and requirements of the intended resident group in mind. It was a six-bedroomed, single-storey building located on a campus operated by the provider. The other services on the campus were not related to the service provided in this centre. The centre was observed to be clean and decorated in a homely manner with pictures on many of the walls, and rooms recently repainted. Both residents told the inspector that their bedrooms were comfortable and included everything they needed. One resident spoke to the inspector about how much more confident they felt attending to their personal care in the centre than at home due to the facilities provided. There was a spacious kitchen and dining area with lots of storage available. This enabled residents to bring their own food, if they so wished. The design of the building and the fittings installed allowed for residents to participate in cooking, laundry and other tasks but staff advised that most often they did not, with most viewing their stays in the centre as a holiday. One resident echoed this sentiment, comparing the centre to a

hotel and being there like a holiday from their day-to-day responsibilities. There was a large television and fish tank in the living room area, as well as a suite of comfortable furniture. The layout of the building provided a shared ensuite bathroom for every two bedrooms, as well as a separate main bathroom. It had been decided that residents would not share a bathroom during the pandemic. This was how the maximum capacity of four residents had been decided.

Although clean, well-resourced and well laid out, there were some issues with the premises, highlighted in the previous HIQA report that had not yet been addressed. For example, fittings in one bathroom required replacement. Other areas identified as requiring improvement in that report were still evident during this inspection. Although there had been a number of audits in the centre, these and other matters raised during this inspection had not been identified. As a result, it was determined that the monitoring and review systems operating in the centre required review to ensure they supported the sustainable delivery of a high quality service and quality improvement in the centre.

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

## Capacity and capability

Although there was clear leadership and effective day-to-day management in the centre, the provider needed to further improve the governance and management systems to ensure effective oversight, sustainable delivery of a high quality service, and the implementation of service improvement initiatives.

The person in charge had been in the role since August 2016. As well as managing this centre they also managed another service (not a designated centre) that comprised seven apartments in Limerick city. They informed the inspector that they split their working day between the two services, starting each morning in this centre. The person in charge reported to one of the persons participating in management. The other person participating in management had taken on a national role with the provider. The staff team included a team leader, care assistants and four nursing staff. The lines of reporting and accountability were clear in the centre.

The team leader had protected administration time and also provided direct support to residents. This ensured a high level of staff supervision. Staff also attended regular team meetings and one-to-one supervision sessions with the person in charge. Records reviewed indicated that a range of relevant topics were discussed. These also provided opportunities for staff to raise any concerns they may have

about the quality of the service provided to residents in the centre. When discussing supervision, it was identified that the person in charge's own supervision was not taking place as frequently as the provider's policy required.

The last annual review of the centre had taken place in March 2020 and was completed by a person participating in management. They found the centre to be in full compliance with the regulations. When asked why a more recent review hadn't been completed, the inspector was informed that as the service had temporarily closed and then re-opened in July 2020, it was planned to complete the annual review in July 2021. On the day of this inspection, 29 July 2021, the annual review had not been completed.

The provider had arranged for unannounced six-monthly visits to the centre which resulted in a written report on the safety and quality of support provided, as is required by the regulations. Due to the ongoing pandemic the two most recent visits had taken place remotely, with the person in charge providing requested information and then speaking to the auditor. As part of the most recent visit, that the auditor had also spoken with a resident and another member of the staff team. A number of areas of service provision were reviewed and actions had been developed to address any shortcomings identified. As part of these audits, the findings and required actions of the most recent HIQA inspection were reviewed. Despite this, the outstanding issues identified on this inspection regarding the premises and complaints were not noted. Similarly, following the last HIQA inspection the provider had committed to the development and weekly use of a template to collate and analyse resident feedback to drive improvement in the centre. While this template was developed, when reviewed during this inspection, it was noted that the last entry was made in April 2019. Again this had not been identified in either of the six-monthly reports, or the March 2020 annual review.

As outlined in the opening section of this report, the majority of complaints recorded in the centre were addressed promptly. Possibly due to the recording template in use, whether the complainant was satisfied with the outcome of the complaint was not recorded. This is a requirement of the regulations and was highlighted in the last HIQA inspection. The most recent complaint was made in March 2021 by a relative of a prospective resident of the centre. This complaint was not made directly to the provider and was instead made to the funding body who forwarded it to the person in charge. On receipt of this information, it was documented that it would be treated within the service as a complaint. However, the provider's complaints policy was not implemented. Although this matter had been raised with senior management and there had been some follow up with the person who forwarded the complaint, at the time of this inspection the provider had not responded directly to the complainant and the matter was not resolved. It is possible that this outstanding issue had contributed to the prospective resident not progressing with their application to attend the service.

The centre was staffed by a committed and consistent team. Some staff had been redeployed to work in other centres during the pandemic as this centre was closed temporarily and then provided the service at a reduced capacity. When reviewing the training records, it was identified that one staff member who had recently

returned to the centre and the person in charge required training in fire safety. A recent addition to the team had yet to complete training in the management of behaviour that is challenging. All other mandatory training had been completed.

## Regulation 14: Persons in charge

The person in charge met the requirements of this regulation. They clearly knew the needs of the residents well and had the required qualifications, skills and experience required to manage the centre.

Judgment: Compliant

## Regulation 15: Staffing

The number, qualifications and skill mix of staff in the centre was appropriate to the residents' assessed needs. There was a consistent staff team working in the centre which ensured continuity of care for the residents. The information and documents as outlined in Schedule 2 of the regulations were not examined in this inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

At the time of the inspection, two staff members were awaiting refresher training in fire safety and one staff required training in the management of behaviour that is challenging. It was also noted that while the person in charge was regularly providing staff supervisions, they themselves were not receiving supervision at the frequency outlined in the organisation's policy.

Judgment: Substantially compliant

## Regulation 23: Governance and management

It was evident that there were management systems in place to ensure that the service provided to residents was safe, person-centred and of a high quality. However, it was noted that a number of actions from the 2019 HIQA inspection

report had not been followed up. In addition, although planned, an annual review had not been completed in the last 16 months.

Judgment: Substantially compliant

## Regulation 24: Admissions and contract for the provision of services

Applications for admission were determined based on transparent criteria. Residents had the opportunity to visit the centre prior to staying overnight if they wished. In the majority of files reviewed, there was evidence of a written and signed service agreement. However, a resident who had stayed in the centre in the week before this inspection had yet to sign such an agreement.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The statement of purpose required review to ensure that all of the required information was accurate, including the names of the persons participating in management, the whole time equivalent of the person in charge and the specific care and support needs the centre is intended to meet.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

As was identified in the last HIQA inspection of this centre, the complainant's satisfaction with the outcome was not noted on the records of complaints. The practice regarding complaints was inconsistent in the centre. Management had not followed the provider's own policy in response to one complaint. As a result almost four months after making a complaint, the complainant had not received a response from the provider and the matter was not resolved.

Judgment: Not compliant

## Quality and safety

The inspector found that the quality and safety of support provided in the centre was of a high standard. A review of documentation and the inspector's observations indicated that residents' rights were promoted, a person-centred culture was in place, and that residents enjoyed spending time in the centre. As outlined already in this report, some longstanding issues with the premises needed to be addressed.

The person in charge described to the inspector the assessment process completed from the time that a person is referred to the service. This includes key staff meeting with the resident and the collection of detailed written information from the person, where appropriate their family, and their general practitioner in advance of any visit. This assessment will identify if the service can meet the resident's individual needs and also informs the development of the resident's personal plan. Prior to a return visit the centre, the resident or their representative is contacted to assess if any changes have occurred that need to be reflected in their personal plan. These changes are then added with as much input from the resident as possible either in advance or during the visit. From the sample reviewed there was evidence of regular review, and where appropriate, updating of personal plans. There was also evidence of further medical input, as appropriate, into healthcare plans. For example, a treating doctor had contributed to, and signed, a reviewed epilepsy management plan. It was outlined in the centre's statement of purpose that not all healthcare needs could be met in the centre, however where appropriate nursing staff were rostered to work with those assessed as needing their input during their stay.

At the beginning and end of each visit, every resident is supported to complete an admission and discharge form. This documents the residents' plan for their stay, including any activities they wish to participate in. Prior to leaving, any activities that occurred are noted and there is also an opportunity to document feedback on the service provided. From the sample reviewed it was clear that residents participated in a variety of community based activities that they enjoyed. It was also noted that any appointments they wished to attend were facilitated by the staff team.

As residents only stayed in the centre for short periods of time, most often they did not have visitors. The person in charge explained, and it was documented in the local COVID-19 plan, that outdoor visits could be facilitated if requested. Residents were able to maintain contact with their families as much as they wanted with most doing so independent of staff support. Wireless internet access was available in the centre to support this.

As outlined in the opening section of this report, although there were many positives about the premises, some longstanding issues needed to be addressed. These included rusty fittings / equipment in the main bathroom and the flooring in the sluice room. Although flooring had been replaced in the bathrooms the previous month, the sluice room had been left out in error. The person in charge informed the inspector that it would be replaced but no date had been confirmed.

It was noted in the last HIQA inspection report that there was some duplication and inconsistency between two sets of fire safety records in this centre. While no inconsistencies were identified on this occasion, there were still two sets of fire

documentation which was confusing and made finding specific records difficult. Management informed the inspector that it was planned to review these systems. Staff were completing daily and weekly checks of various components of the fire management systems in place. There was also evidence of servicing of equipment and fire safety systems by appropriate professionals and the completion of evacuation drills in the centre.

## Regulation 10: Communication

Staff were aware of the communication needs and preferences of residents. Television, radio and wireless internet were available in the centre.

Judgment: Compliant

## Regulation 11: Visits

Residents were free to receive visitors if they wished. Due to the ongoing COVID-19 pandemic, there were specific guidelines in place to facilitate visitors if requested.

Judgment: Compliant

## Regulation 12: Personal possessions

Residents had access to and retained control of their personal property, possessions and finances while in the centre. Where support was required, there were systems in place to meet these needs.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents were supported to participate in activities in line with their interests and abilities. These included community based activities that residents may not ordinarily have the opportunity to be involved in. Where it was requested, staff supported residents to continue to attend any education, training or employment opportunities during their stay in the centre.

Judgment: Compliant

## Regulation 17: Premises

The design and layout of the centre met the needs of the residents. The necessary equipment was available for use. While clean, comfortable and decorated in a homely manner, there were some longstanding maintenance issues that needed to be addressed.

Judgment: Substantially compliant

## Regulation 18: Food and nutrition

Residents had the opportunity to buy, prepare and cook their own meals if they wished. Choices were available and residents' preferences were known and accommodated by staff. Staff were aware of and skilled in providing support to residents who required assistance or had specific dietary needs.

Judgment: Compliant

## Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19.

Judgment: Compliant

## Regulation 28: Fire precautions

The centre had effective fire safety management systems. The fire detection and alarm system, equipment and emergency lighting were regularly reviewed by a competent person. Some staff required training, this finding is reflected in the finding for Regulation 16.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Each resident had a comprehensive assessment that resulted in the development of a personal plan. Residents were encouraged to be involved in the development and regular review of these plans.

Judgment: Compliant

## Regulation 6: Health care

Appropriate healthcare was provided to residents in line with their personal plans. Nursing staff were allocated to work in the centre, if required. Staff also facilitated medical appointments, where these were scheduled to occur during a resident's stay.

Judgment: Compliant

## Regulation 8: Protection

There were no safeguarding concerns in the centre at the time of this inspection. Of the sample reviewed, all residents had an intimate and personal care plan in place that considered residents' dignity and areas of independence. All staff had received training in relation to safeguarding residents and the prevention, detection, and response to abuse.

Judgment: Compliant

## Regulation 9: Residents' rights

Residents had opportunities to exercise choice and control throughout their visits to the centre. There was evidence that residents consented to and made daily decisions regarding the support they received.

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 | Substantially compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Admissions and contract for the provision of services | Substantially compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 34: Complaints procedure | Not compliant |
| **Quality and safety** | |
| Regulation 10: Communication | Compliant |
| Regulation 11: Visits | Compliant |
| Regulation 12: Personal possessions | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 27: Protection against infection | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Cairdeas OSV-0002651

## Inspection ID: MON-0033675

## Date of inspection: 29/07/2021

**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:<br>• PICs supervision took place on 09/08/2021 and will be completed at minimum on a quarterly basis in line with organisational policy going forward, dates for remainder of 2021 have been agreed.<br>Outstanding training modules of Fire and MAPA were completed by 18/08/2021. | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• Annual review scheduled for completion on week beginning 06/09/2021.<br>• PIC has reviewed all outstanding actions and taken steps to ensure full completion of same.<br>• Rusty bathroom fitting in main bathroom was replaced 18/08/2021, work on sluice room floor to be completed by 30/09/2021.<br>Existing Compliments/Complaints log being reviewed and amended to reflect complainant Satisfaction with resolution/outcome. This will be completed by 30/09/2021. | |

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| Regulation 24: Admissions and contract for the provision of services | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:<br>PIC and TL visited with family of resident for whom Contract for provision of support required signature, this is now on file, completed on 18/08/2021.<br>Review of all residents' files to ensure all have accurate and up to date Contract of Care has been completed. | |
| Regulation 3: Statement of purpose | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose:<br>• Statement of Purpose reviewed and updated to accurately reflect service provision and arrangements for isolation on 16/08/2021.<br>• Updated floor plan emailed to HIQA on 16/08/2021. | |
| Regulation 34: Complaints procedure | Not Compliant |
| Outline how you are going to come into compliance with Regulation 34: Complaints procedure:<br>• PIC has reengaged with the complainant and the HSE Case Manager to agree a resolution to the complaint in line with the organisation's complaints policy this was completed on 30/08/2021.<br>• Refresher training to be scheduled on the organisation's complaints policy for the PIC and the service team by 31/10/2021. | |
| Regulation 17: Premises | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>• A weekly review of maintenance log to be added to the service weekly audit tool by 03/09/2021.<br>• Bathroom fitting was replaced on 18/08/2021.<br>• Works on sluice room floor to be completed by 30/09/2021. | |

## 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. | Substantially Compliant | Yellow | 18/08/2021 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 09/08/2021 |
| 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. | Substantially Compliant | Yellow | 30/09/2021 |
| Regulation 23(1)(c) | The registered provider shall ensure that management | Substantially Compliant | Yellow | 30/09/2021 |

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| | systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 23(1)(d) | The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards. | Substantially Compliant | Yellow | 10/09/2021 |
| Regulation 24(3) | The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre. | Substantially Compliant | Yellow | 18/08/2021 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 16/08/2021 |
| Regulation 34(2)(d) | The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her | Not Compliant | Orange | 30/08/2021 |

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| | complaint and details of the appeals process. | | | |
| Regulation 34(2)(f) | The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied. | Substantially Compliant | Yellow | 30/09/2021 |
| Regulation 34(3)(a) | The registered provider shall nominate a person, other than the person nominated in paragraph 2(a), to be available to residents to ensure that: all complaints are appropriately responded to. | Not Compliant | Orange | 30/08/2021 |