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:	Highfield House
Name of provider:	RehabCare
Address of centre:	Longford
Type of inspection:	Announced
Date of inspection:	18 November 2021
Centre ID:	OSV-0002669
Fieldwork ID:	MON-0026923

About the designated centre

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

Highfield House is located close to a town in Co. Longford and comprises of one large two-storey dwelling. The centre provides residential care for up to five male and female adults with disabilities and other healthcare related needs. Each resident has their own bedroom. Communal areas include a sitting room, a fully equipped kitchen, a dining room, a relaxation room, a number of bathroom facilities, a utility room and a secure garden area. There is also an office for staff and a large private garden to the front and rear of the property with adequate space for private parking. There is a separate area linked to the main house and accessible through the utility room and through a separate front door, which is used for day programmes for some residents. This area contains an activities room, kitchen/dining area and a sensory room upstairs. The centre is staffed on a 24/7 basis by a person in charge, a team leader and a team of support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 18 November 2021	9:50 am to 5:45 pm	Angela McCormack	Lead

What residents told us and what inspectors observed

The inspector found that the social care needs and general wellbeing of residents who lived at the centre was promoted, and that care was delivered in a person-centred manner. Residents who the inspector met with during the day of inspection appeared content in their environment, and comfortable with the supports provided by staff members. However, significant improvements were needed in fire precautions to ensure that the home was safe at all times, and in compliance with the regulations.

The designated centre provided full-time care to five residents. The inspector got the opportunity to meet with four residents during the evening of inspection while adhering to the public health guidelines of the wearing of a face mask and social distancing. In addition, the inspector met and spoke with staff who were working on the day.

On arrival to the centre in the morning, the inspector met with the team leader and person in charge. The inspector was informed that all five residents had left for their day services. Three residents were attending a day service external to the centre and two residents were availing of day programmes in the area adjacent to the main building, which was also part of the designated centre.

The inspector was shown around the house by the staff on duty. The house was a large detached house, in which there were security gates to access the driveway. There was a separate area adjacent to the house, which also formed part of the centre, and was used as an area for day programmes for two residents. This had also been used as an isolation area during a recent COVID19 outbreak and formed part of the centre's preparedness plan for COVID-19 outbreaks. This area contained an activities room, bathroom, kitchen/dining area and a sensory room upstairs. There was a large garden area out back, which contained garden furniture, poly tunnels, a small trampoline, and some footballs. There were double doors leading out from the sitting-room, dining-room and activities room to the back garden. On one side of the back garden a fence was erected along the garden, which meant that access to the front of the house from the back garden could be gained through one side of the house only. The centre was observed to have a range of easy-to-read and pictorial notices located around the house; including visual staff rotas and activity schedules. The centre was also personalised with residents' art work and photographs, which helped to create a homely atmosphere.

The main house appeared spacious for the numbers of residents. Each resident had their own bedrooms, which were located upstairs. Two of the bedrooms had en-suite bathroom facilities. There was a large sitting-room which had couches and chairs, and a separate 'movie room' in which there were large bean bag chairs and a massage chair. There was a kitchen and dining area, and also a separate room for dining in. The laundry facilities were located in the utility room, which was located between the main house and the apartment. Residents were observed to be freely

moving around the centre, with some residents observed doing art work in the dining area and other residents relaxing in separate communal areas of the house.

The inspector got the opportunity to meet with four residents later in the day. Residents communicated with the inspector on their own terms, and were observed to be supported by staff in doing arts and crafts and getting snacks and beverages. Some residents were painting stones, and one resident was painting their finger nails. Residents appeared content and comfortable with staff supporting them. As the inspector was leaving, residents were preparing for dinner and one resident was observed lying on the couch and appeared to be relaxed. The inspector was informed that the resident often liked to rest after their day.

Staff spoken with appeared knowledgeable about residents' needs and communication preferences and this was observed in practice. Residents were reported to be getting on well at this time and to have coped well with the restrictions during COVID-19. The centre experienced a COVID-19 outbreak the previous month, and the inspector was informed about how residents got on and how they were provided with supports from members of the multi-disciplinary team during their period of isolation, which helped to support them.

The inspector also reviewed documentation such as personal plans, management audits and questionnaires that were completed by residents and their families, in order to get a more detailed view of the lived experience of residents. The provider had sought family's views on the service as part of the 2021 annual review, and this feedback was reviewed by the inspector. Family members expressed satisfaction with the service provided with some feedback saying that the 'service is excellent', 'service is wonderful' and one family member complimented the use of 'communication passports' as something that the service does well.

Residents were supported to complete questionnaires prior to the inspection. All questionnaires reviewed indicated that residents were satisfied with the service provided and the supports given. It was noted that residents reported that they enjoyed a range of activities in the centre which included; using the sensory room, the massage chair, music, 'take-away evenings', arts and crafts, doing puzzles, looking at magazines, jewellery making and playing on games consoles. Activities that residents reported to enjoy in their community included; reflexology, horse riding, swimming, visiting cafes and going to visit church. It was reported that one resident took part in a virtual 5km walk recently for a charity, for which they received a medal.

Overall, residents appeared happy and content in their home environment and with staff supporting them. 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 inspector found that there was a good organisational structure with clear lines of accountability; however improvements were required in the monitoring and oversight of the centre to ensure that the centre was safe and to a high quality at all times. An urgent compliance plan was issued in relation to fire safety risks and this will be discussed further in the report. In addition, improvements were required in the oversight arrangements as there were gaps found in Schedule 2 documentation, an unsigned contract of care, gaps in documentation of one resident's personal goals and inaccurate risk ratings for some risks.

A full application to renew the registration of this centre had been received. Some minor amendments were required to the Statement of Purpose and Residents' Guide; however these were addressed on the day of inspection.

A range of audits were carried out by the management team; including unannounced six monthly provider audits and internal audits in areas such as health and safety, medication management and hazard identification. However, the inspector found that these audits failed to identify issues found on inspection particularly, in relation to fire safety, for which an urgent compliance plan was issued. Furthermore, improvements in the ongoing oversight arrangements were required, as the management audits did not effectively identify areas required for improvements such as inaccurate risk ratings, gaps in staff files documentation, unsigned contracts of care and documentation of resident's personal goals. In addition, where issues had been identified through internal audits, these were not followed up in a timely manner. For example; one action relating to loose wires was identified on the hazard identification audits over a three month period, before being addressed and the fire risk assessment noted that not all self-closers on fire doors were operating correctly, yet no action had been identified to address this.

The person in charge worked full-time and was supported in their role by a team leader, persons participating in management and a team of support workers who worked directly with residents. The person in charge was responsible for one other designated centre and divided their time between both centres.The staff rota was reviewed, and demonstrated that there was a consistent staff team in place to ensure continuity of care to residents. Some staff spoken with had worked with residents for many years. There was a waking night staff in place to support residents with their needs and a management on-call system for out-of-hours, should this be required. A sample of staff files were reviewed and it was found that there were gaps in the Schedule 2 documents as required under the regulations.

Staff were offered training opportunities for continuous professional development and in supporting them to have the skills and knowledge to support residents with their needs. Training records were reviewed which demonstrated that staff were up-to-date with their training requirements. The management team carried out supervision sessions with staff, and staff spoken with said that they felt well supported and could raise any issues of concern to the management team if required. Regular team meetings occurred between the person in charge and staff team members, in which a range of topics were discussed and demonstrated that

there were opportunities for staff to raise any points for discussion.

In summary, while there was a good organisational structure in place, improvements were needed in the ongoing and consistent monitoring of systems in the centre to ensure that audits effectively identified areas of non compliance and actions for improvements to ensure a safe and high quality service.

Registration Regulation 5: Application for registration or renewal of registration

A full application to renew the registration of the centre was submitted as required.

Judgment: Compliant

Regulation 15: Staffing

A review of the roster indicated that there was a regular team of staff to ensure continuity of care to residents. However a review of a sample of staff files found gaps in the documentation as required under Schedule 2 of the regulations. This related to gaps in employment, references and up-to-date photo identification.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with training opportunities for ongoing professional development and to ensure that they had the skills required to meet residents' needs. The local management carried out regular supervision sessions with staff, and staff members spoken with said that they felt well supported in their role.

Judgment: Compliant

Regulation 22: Insurance

The provider ensured that there was up-to-date insurance in place.

Judgment: Compliant

Regulation 23: Governance and management

The ongoing monitoring and oversight by the provider and management team required improvements to ensure that fire safety risks were identified and actions completed in a timely manner. In addition, the management auditing systems required strengthening as they were not effective in identifying some of the areas for improvement as found on inspection. This included; gaps in staff files, some aspects of risk management and documentation relating to residents' personal goals.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

Residents had contracts for the provision of services, which included any fees to be charged; however this had not been signed and agreed by the provider.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and was found to contain all the requirements under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

Policies and procedures that are required under Schedule 5 of the regulations were reviewed and found to be in place. The provider had an auditing system in place to review the policies and procedures, and all had been reviewed as required, with a small number in draft form awaiting final approval.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents received a person-centred service where their wellbeing was promoted and their interests and choices respected. Residents who the inspector met with appeared to enjoy living at the centre and were observed to be comfortable in their environment and with staff supporting them. However, improvements in risk management and fire safety would further enhance the quality and safety of care.

Residents had personal profiles in place which included information about their support requirements and routines. Residents' annual review meetings were held with the maximum participation of residents' and their families. Residents were supported to identify personal goals and a sample of files reviewed demonstrated that these goals were under review. However, documentation in relation to one resident's meetings and goals achieved, required improvements to ensure that specific, realistic and time bound goals were clearly set and met within agreed time lines. This is covered under the governance and management regulation to ensure effective and ongoing monitoring of the centre.

Safeguarding of residents was promoted in the centre through staff training, review of incidents that occurred and the development of personal and intimate care plans. Where concerns of a safeguarding nature arose, these were investigated in line with the procedures. Safeguarding plans that were in place were signed by all staff and discussed at team meetings, which demonstrated good oversight in this area.

Residents who required supports with behaviours of concern had specific plans and protocols in place, which had a multidisciplinary input. Restrictive practices that were in place were under ongoing review and the inspector found that these were reviewed with residents' representatives and agreed with them. Staff spoken with demonstrated good knowledge about restrictive practices and the rationale for their use, and explained about how they were the least restrictive option and proportionate to identified risks.

The provider ensured that there were good systems in place for the prevention and control of infection including staff training, health and safety audits, posters on display around the house about prevent infection transmission, use of personal protective equipment (PPE) and availability of hand sanitisers at entry points. In addition, there were systems in place for the prevention and management of risks associated with COVID19; including up-to-date outbreak management plans. The management team conducted a review of a recent outbreak in the centre which demonstrated the provider's willingness to learn from, and to review the systems in place to reduce the risk of any future infection outbreaks. Observations on the day showed that there was a commitment to adhere to infection control measures and there was a clear contingency plan in place and protective mitigating measures in place such as enhanced cleaning schedules, pedal bins for PPE located around the house, ongoing symptom checks and refresher training for staff.

There were systems in place for the identification, assessment and management of risk, including an up-to-date risk management procedure. In general, risks that had been identified at service and resident level had been assessed. However, the ratings of some risks required review, as they were not reflective of the actual risks posed such as risks of self-injurious behaviours and fire safety.

On the day of inspection the inspector found that the provider did not ensure that there were adequate arrangements in place for effective fire protection. Issues in relation to fire doors, fire evacuation procedures, fire drills under different scenarios and assessments for fire risk were identified on the day. Under this regulation the provider was required to submit an urgent compliance plan to address an urgent risk. The provider's response did provide assurance that the risk was adequately addressed, and a plan of works was included on the compliance action plan.

In summary, residents were provided with person-centred care and support and their individual interests and uniqueness were valued. However, risks associated with fire safety required urgent actions to ensure compliance with the regulations and to provide assurance that residents were provided with a safe home at all times.

Regulation 20: Information for residents

A guide for residents was in place, and contained all the requirements under the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a policy and procedure for risk management. Risks, where identified, were assessed and kept under review. However, the risk ratings applied to some risks were not reflective of the actual risks posed in line with the organisation's policy and procedure. For example; risks that were evident in incident forms that occurred frequently were rated as rarely occurring. In addition, there was duplication in the documentation maintained in relation to some risks which made it difficult to establish which risk assessments were the most up-to-date.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had systems in place for infection prevention and control; including

staff training, use of personal protective equipment, enhanced cleaning and the availability of hand sanitizers. There was an up-to-date contingency plan in the event of COVID19 outbreak, and each resident had been assessed for self-isolation in the event of being a suspected case of COVID19. The centre had experienced an outbreak recently and the management team had undertaken a review and analysis of the outbreak, so that learning could be taken and shared with other colleagues.

Judgment: Compliant

Regulation 28: Fire precautions

On the day of inspection the inspector found that provider did not ensure that there were adequate arrangements in place for effective fire protection. The following issues were identified on the day;

- One fire door leading from the utility area, in which the laundry appliances were located, was damaged. The surrounding panel on the latch on one side of the door was missing, and the handle and surrounding panel on the other side were loose. When closed, the door was visibly loose in the door jam, and the magnetic holding device was not working.
- There was no evidence that inspections had been completed by a competent person on the fire doors in place to ensure that they were effective in containing fire.
- The second door leading from the utility room to the main living area of the house was not a fire door, and this had not been risk assessed as to what mitigating control measures were required.
- The sensory room door which was located upstairs was not a fire door, and this had not been risk assessed as to what mitigating control measures were required.
- The recent fire risk assessment completed by the person in charge identified that not all self closers on fire doors were working; however there was no control measures in place or actions identified to resolve this.
- The fire evacuation procedures did not include the deactivation of the security gates to allow emergency services to enter.
- The fire evacuation procedures stated that residents may require a transport technique to move them, which the inspector was informed was not in use.
- The fire evacuation procedures stated to leave residents in their bedrooms with the doors closed, if they refused to move.
- The fire drills did not include a scenario in which residents may be required to exit from the back exits to ensure that they could be safely evacuated to the assembly point, which was at the front of the house.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents' health, personal and social care needs had been assessed, and support plans were developed where required. Resident's annual reviews were held and demonstrated maximum participation of residents and their family representatives as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviour of concerns had comprehensive behaviour support plans in place which had been developed in a multidisciplinary approach. Restrictive practices were kept under review and residents' representatives were consulted and involved in the review as part of the personal planning process.

Judgment: Compliant

Regulation 8: Protection

Residents were safeguarded through staff training and the adherence to the safeguarding procedures when any concerns arose. Safeguarding was discussed regularly at team meetings and kept under review through management audits. Staff spoken with were aware of what to do in the event of a concern of a safeguarding nature.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Highfield House OSV-0002669

Inspection ID: MON-0026923

Date of inspection: 18/11/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A full review of staff files will be undertaken by the PIC in consultation with the HR Team to ensure that all information pertaining to schedule 2 is accessible and up to date within all staff files. The review of files was completed 16/12/2021 and are updated.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The providers Lead Health, Safety & Risk Manager completed a review of all fire procedures in the service on the 23.11.21. This included a review of all fire safety concerns raised in this report, service documentation in terms of fire safety including PEEPs and mobility support requirements. The PIC shared the learning from this review at a team meeting on 15.12.21. Outcomes and learnings from this report was shared on the Regional PIC meeting on the 25.11.21 and on Rehab Quality & Safety Executive meeting on the 30.11.21. • A full annual health and safety audit which included a further review of fire safety measures was conducted on site 23.11.21. This was completed by the PIC supported by the Lead Health, Safety & Risk Manager. The PIC has shared outcome of this audit with the staff team at planned team meeting on the 15.12.21. • The PIC conducted a review of Regulation 28 related Risk Assessments on the 22.11.21 and reviewed each individual risk item contained within. •All staff completed a refresher in Health and Safety Essentials by the 3.12.21.	

• Health & Safety which includes Risk Management is part of the agenda at all monthly team meetings.

• The management of risks and Health and Safety will be reviewed at monthly meetings between the PIC and ISM. This will be completed ongoing from week commencing 6.12.21 for a 6 month period to 06.06.22.

•Provider Audits were carried out remotely in 2021, plans are in place to restart on site audits in 2022 (pending Covid restrictions).

•Weekly Team Leader and Monthly PIC audits will continue, any issues will be escalated to the ISM. PIC will select a resident's file each month to review support plans.

• The Integrated Service Manager (ISM) will meet with the PIC on a monthly basis to review the service and monitor performance. This meeting will be documented with actions agreed and reviewed at subsequent meetings.

•All actions arising from this report will be uploaded to the Provider's Action Tracking system. The actions will be updated by the Team Leader/PIC and validated by the Integrated Services Manager. This will be completed by the 31.01.22 and monthly update of compliance actions will take place going forward. This system is utilized to generate monthly reports for the senior management team and the Board, monthly reporting will continue until all actions relating to non-compliances are closed.

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:
• The Person in Charge has signed all contracts of care this was completed on 18.11.21.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge attended a risk management workshop on 01.12.21. A full risk review will be completed by the Person in Charge to ensure that all risks are rated in line with the risk management policy. All duplication of paperwork will be reviewed and removed during the risk review. Risk review will be completed by 17.12.21.

• The Organisation's Chief Risk Officer delivered a Risk Management Workshop on the

1.12.21.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: An engineer conducted an assessment of fire detection and containment on site on the 24th of November. Fire remediation schedule of works includes replacement of 6 fire doors. Work has commenced and will be completed by 10.1.2022. Risk assessment will be completed on areas concerned whilst awaiting doors. This will be completed by the 30th of November.

• The providers Lead Health, Safety & Risk Manager completed a review of all fire procedures in the service on the 23rd of November 2021. This included a review of all fire safety concerns raised in this report, service documentation in terms of fire safety including PEEPs and mobility support requirements. The PIC will share learning from outcome of this review at a team meeting on 15.12.21. Outcomes and learnings from this report was shared on the Regional PIC meeting on the 25.11.21 and on Rehab Quality & Safety Executive meeting on the 30.11.21.

• A full annual health and safety audit which will include a further review of fire safety measures will be conducted on site by 1.12.21 date. This will be completed by the PIC supported by the Lead Health, Safety & Risk Manager. The PIC will share outcome of this audit with the staff team at planned team meeting on the 15.12.21

• All risks will be managed in line with Rehab Groups risk management policy.

• The PIC conducted a review of Regulation 28 related Risk Assessments on the 22.11.21 and reviewed each individual risk item contained within.

• The Organisation's Chief Risk Officer delivered a Risk Management Workshop on the 1.12.21.

• All staff completed a refresher in Health and Safety Essentials by the 3.12.21

• Health & Safety which includes Risk Management is part of the agenda at all monthly team meetings.

• The management of risks and Health and Safety will be reviewed at monthly meetings between the PIC and ISM. This will be completed ongoing from week commencing 6.12.21 for a 6 month period to 6.6.22.

• Trailing wires in the sensory room were first reported on 27.08.21 at which point the room was decommissioned for use and noted as such in the monthly hazard check. Remedial works were protracted due to the unavailability of qualified professional. Covid outbreak occurred on site on the 12.10.21 at which point the site was deemed in

lockdown for 10 days. Works were carried out on the 16.11.21, at which point the room became open to use.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/12/2021
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	31/01/2022
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of	Substantially Compliant	Yellow	18/11/2021

	giving consent, the terms on which that resident shall reside in the designated centre.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	17/12/2021
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	26/11/2021
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Red	26/11/2021
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Red	26/11/2021
Regulation 28(3)(d)	The registered provider shall	Not Compliant	Orange	26/11/2021

	make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			