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: | Praxis Care Mullingar |
| Name of provider: | Praxis Care |
| Address of centre: | Westmeath |
| Type of inspection: | Unannounced |
| Date of inspection: | 01 February 2022 |
| Centre ID: | OSV-0001915 |
| Fieldwork ID: | MON-0032924 |

## About the designated centre

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

The service provides residential care to six male and female residents. Four of the residents live here on a full time basis. Two residents live here on a shared care basis meaning that one resident stays for two weeks and then goes home and the other resident then stays for two weeks. The staff team consist of direct support workers, team leaders and the person in charge. There are three staff on duty during the day and two staff at night (one of whom is on a sleep over). An additional staff is also provided during the day to facilitate activities in the community. The centre comprises of a dormer style bungalow situated outside a large town in County Westmeath. Each resident has their own bedroom which has been decorated to the residents taste and choice. Residents are supported by a range of allied health professionals in line with their assessed needs. Most of the residents attend a day service either full time or on a part time basis. Residents who choose not to attend are supported by staff to engage in activities of their choice.

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

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| 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 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
|---|---|---|---|
| Tuesday 1 February 2022 | 10:20hrs to 18:45hrs | Anna Doyle | Lead |

## What residents told us and what inspectors observed

Overall, while some of aspects of the care provided were observed to be to a good standard and residents appeared to have a good quality of life here, a number of improvements were required to ensure that a safe service was being provided. Fire safety measures required significant review; and the premises, some risk management processes and restrictive practices also required improvements. One resident also provided feedback on the provision of day services.

The centre was spacious and clean. However, it had been identified by the provider that a significant amount of upgrades were required to the property. This is discussed in more detail under the quality and safety section of this report.

Residents had their own bedrooms which had been decorated with their own personal possessions. All of the bedrooms required an upgrade. It was evident that the residents enjoyed art and some of their artwork was displayed around the centre.

The inspector met all of the residents over the course of the inspection one of whom gave some feedback on the services provided here. Three of the residents were observed having dinner in the evening time and the meal looked very appetising. The residents said they were enjoying it and one resident commented that the staff member who had prepared the meal was a great cook.

Another resident was observed listening to their favourite music in the conservatory. While another was observed relaxing in the evening watching television and engaging with staff.

The inspector observed that the residents were comfortable in the presence of staff and that the staff treated the residents in a respectful manner at all times. They ensured residents were consulted before the inspector entered their bedroom.

One resident who showed the inspector their bedroom, spoke for a short time in the presence of staff about some of the things they liked to do and some of their hobbies. For example; they liked a particular movie character and engaged in a game related to this character with staff members which they really enjoyed.They were observed asking the person in charge to play this game during the inspection and was smiling and very happy when the person in charge agreed to partake in the game.

Another resident talked about what it was like to live in the centre. They said they liked living there, really liked the staff, the food and said if they were not happy they would talk to a staff member or the person in charge. They did, however, say that they would like to have more things to do outside of the centre as they used to attend a day service two days a week and now they were only attending one day a

week.

It was also evident that the resident knew about the care and support they required in the centre from staff. They were aware of their health care needs and the activities happening for the week ahead, which they said were planned at the start of every week. For example; on Saturday, they were planning to go shopping and then relax at home on Sunday.

Some of the residents attended day services which had not resumed for some since the COVID 19 restrictions had begun.The person in charge told the inspector that a meeting had been held the day before this inspection where a proposed date had been agreed for residents to return to day services. Given one residents feedback to the inspector, this needed to be reviewed to ensure that residents had activities that they liked to engage in on a regular basis.

Weekly 'key worker' meetings were held with residents to talk about activities they would like to do. These meetings were an opportunity for residents to share any concerns they may have or plan activities they may wish to do. This meant that their preferences were considered when planning activities. For example; one resident loved shopping and shopping trips were regularly planned with the resident. These meetings were also an opportunity to educate the residents on things to keep them safe. For example; one resident had not participated in a fire drill recently and the importance of this was discussed with the resident at their meeting.

There was also a bus available in the centre so as residents could avail of activities further afield. On the day of the inspection residents were out for walks or attending other appointments they had.

The inspector also found examples of where residents could express their preferences and this was one example of them exercising their rights. For example; a communication aid was observed for one resident. This included pictures of particular items of food that the resident liked and was there to enable the resident alert staff by pointing to the picture when they wanted something. Residents were also able to make a complaint. The inspector viewed one complaint made by a resident and this had been followed up and dealt with by the person in charge.The resident was satisfied with the outcome of the complaint.

However, one resident chose not to accept some supports that were in place to keep them safe. While the inspector found that this was respecting the rights of the resident, they were not assured given the risks associated with this refusal, that the impact of this refusal had been fully discussed with the resident. This is discussed under risk management of this report.

As stated one complaint had been recorded in the centre which had been reported by a resident. A number of compliments of the services provided were recorded also. For example; some family representatives had complimented the care being provided to their family member during the pandemic.

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

Overall, the inspector found that centre was for the most part well managed. However, the inspector was not assured about the fire arrangements in the centre on the day of the inspection. Other areas also required improvements including, risk management, general welfare and development, restrictive practices, the premises and personal plans. Given these findings improvements were also required to the governance and management arrangements in the centre to ensure that the provider was meeting the requirements of the regulations.

There was a clearly defined management structure in place, led by a person in charge who provided leadership and support to their staff team.

The person in charge was employed full time in the organisation. They were a qualified professional with a number of years management experience working in disability settings. They demonstrated a good knowledge of the residents' needs in the centre and were aware of their responsibilities under the regulations. The person in charge was also responsible for another designated centre under this provider. To support them with the oversight of this centre, three team leaders were employed. Two of the team leaders met with the inspector and they both had a good understanding of the needs of the residents. The inspector was satisfied that this arrangement was effective at the time of this inspection.

There was a consistent staff team employed and sufficient staff on duty to meet the needs of the residents. The staff team consisted of direct support workers and a team leader was assigned to work during the day and at night. This meant that staff were supervised and supported by a team leader at all times.

Staff met said that they felt very supported in their role and were able to raise concerns, if needed, to a team leader on a daily basis. They were knowledgeable about the residents needs and spoke about some of the residents personal preferences. They confirmed that they had supervision completed every two months and while those records were not viewed during this inspection; all staff met reported that they had no concerns about the quality and safety of care provided to residents.

Staff had been provided with training to meet the needs of the residents and to provide safe care. For example; all staff had been provided with mandatory training in infection control, fire safety, emergency first aid and positive behaviour support. Training specific to this centre was also provided some of which included, the safe administration of medicines, epilepsy, dysphagia and autism. At the time of the inspection all staff training was up to date and where refresher training was due, the

person in charge had booked dates for this training to be completed.

The provider had arrangements in place to monitor and review the quality of care in the centre. An unannounced quality and safety review had been completed in October 2021 along with an annual review for 2021. The actions for improvements identified from these reviews and other audits conducted in the centre were compiled onto a quality enhancement plan. The inspector followed up on a number of the actions and found that they had been completed. For example; one residents plan was being reviewed and all staff were required to sign this plan as read once received. This action had been completed. However, given the findings of this inspection, improvements were also required to the governance and management arrangements in the centre to ensure that the provider was meeting the requirements of the regulations.

The inspector was satisfied that the person in charge was aware of their responsibilities to notify the chief inspector when an adverse incident occurred in the centre.

## Regulation 14: Persons in charge

The person in charge was employed full time in the organisation. They were a qualified professional with a number of years management experience working in disability settings. They demonstrated a good knowledge of the residents' needs in the centre and were aware of their responsibilities under the regulations. The person in charge was also responsible for another designated centre under this provider. To support them with the oversight of this centre, three team leaders were employed.

Judgment: Compliant

## Regulation 15: Staffing

There was a consistent staff team employed and sufficient staff on duty to meet the needs of the residents. The staff team consisted of direct support workers and a team leader was assigned to work during the day and at night. This meant that staff were supervised and supported by a team leader at all times.

Staff personnel files were not reviewed at this inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had been provided with training to meet the needs of the residents and to provide safe care.

Judgment: Compliant

## Regulation 23: Governance and management

The provider and person in charge had arrangements in place to monitor and review the quality and safety care. However, given the findings of this inspection, improvements were also required to the governance and management arrangements in the centre to ensure that the provider was meeting the requirements of the regulations.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The inspector was satisfied that the person in charge was aware of their responsibilities to notify the chief inspector when an adverse incident occurred in the centre.

Judgment: Compliant

## Quality and safety

Overall the residents spoke about having a good quality of life however, improvements were required in fire safety, the premises, general welfare and development, personal plans, risk management and restrictive practices.

As stated the property was spacious and clean but, as stated earlier in this report significant upgrades were required to the property. The provider had identified this through their own audit and reviews of the premises. The provider's property management team had collated a list of improvements which included bathroom upgrades, painting the premises and upgrading the sun room and kitchen. At the time of the inspection, there were plans in place to remodel the kitchen.

The inspector also identified that some residents had hospital beds even though there was no identified need for these residents to have such beds. This needed to be reviewed. Due to the needs of one resident the dining area was sparsely decorated and not very homely. While this was in line with one resident's needs, it required review to ensure that other residents' meal times experiences were pleasant. A couch in the sitting room also needed to be either repaired or replaced as it had some minor tears in the cushions which could pose a risk in relation to fire and/or infection control.

The inspector reviewed the fire safety arrangements in the centre and was not assured that in some instances residents could be safely evacuated in the centre. The personal emergency evacuation plans (PEEPS) outlined two situations; A and B for residents who slept upstairs which outlined how they should be supported.

In situation B it outlined that if the residents exit was blocked on the stairs or if they refused to evacuate the resident should be informed to shut their bedroom door and remain there until the fire brigade came. Both of the bedrooms had velux windows. The inspector found that one of these windows had been risk assessed as being suitable to use for rescue purposes in the event of a fire. However, the person in charge could not verify if both windows were in line with fire regulations and if the second window could be used for rescue purposes in the event of a fire.

Records were requested to be submitted after the inspection to provide assurances around this. The record submitted after the inspection stated that the velux windows were 'compliant', however, it did not verify how that decision was reached. The inspector was not satisfied with these assurances and this required a more comprehensive response.

The inspector also viewed a record from a fire expert who the provider had requested to visit the centre following the last inspection of this centre. This fire expert wrote a report outlining recommendations for improvement in fire safety measures in the designated centre. Some of the recommendations included, installing a carbon monoxide detector in the boiler room, reviewing the level of staff fire training and to install an additional fire exit downstairs.

The providers own health and safety personnel had written a reply to this expert outlining the measures they intended to take in view of those recommendations. For example; the above recommendations were to be discussed with the property management team. The inspector requested these records, however, there were no records to verify this discussion on the day of the inspection. This did not provide assurances to the inspector and the person in charge was requested to submit assurances around this the day after the inspection.

The records submitted indicated that a meeting had been held on 17 November 2021 confirming that they were satisfied with the current fire exits in the centre. However, it did not reference anything about the carbon monoxide detectors.

In addition, the fire evacuation plan which had last been reviewed on 12/11/2020 did not provide adequate guidance on the evacuation of residents in line with the

providers own fire evacuation strategy. For example; the fire drill records indicated that the type of evacuation was a 'get out and stay out' evacuation. Yet the evacuation plan stated that if a staff member was upstairs, they could direct residents to stay in their bedrooms. This was contradictory of the providers own evacuation strategy for this centre. In addition, given the mobility needs of some of the residents, the fire evacuation plan did not adequately guide staff on duty as to which staff member was responsible for evacuating which individual residents.

The individual social care needs of residents were being supported and encouraged. From viewing a small sample of files, the inspector saw that residents were being supported to achieve personal and social goals and to maintain links with their families and community. Personal plans were in place for all residents. The support plans were reviewed every month and a yearly review had been conducted with the resident, their family representatives and relevant staff members.

However, improvements were required in one residents personal plan who had been assessed as requiring support with a specific type of infection. It was not clear on the day of the inspection whether this was still a need for the resident.

Residents were supported with their health care needs and had as required access to a range of allied health care professionals, to include GP, dietitian, occupational therapy and physiotherapy. Hospital appointments were facilitated where required and care plans were in place to support residents in achieving best possible health. The inspector found from a sample of reports viewed, that where an allied health professional made a recommendation, that this was followed through. For example; an occupational therapist had recommended a grab rail for one resident and this had been installed.

Residents were supported to experience best possible mental health and had access to behavioural supports. Where required, residents had a positive behaviour support plan in place. These plans had recently been reviewed by a behaviour specialist. The staff met were aware of the supports resident's needed in this area. A number of restrictive practices were utilised in the centre. The inspector reviewed a sample of these and found that the rationale for the use of one restrictive practice was not clearly outlined. For example; one resident had a restriction in place around the shower, however, the rationale for this was not clearly outlined. In addition, while restrictive practices were regularly reviewed in the centre by the person in charge, this review did not evidence if the restrictive practice was the least restrictive measure or whether other alternatives had been trialled.

There were systems in place to manage and mitigate risk and keep residents safe in the centre. This included a risk register for overall risks in the centre and individual risk assessments for each resident. Incidents in the centre were reviewed and any actions agreed to mitigate risks had been implemented. For example; one resident had sustained an injury after a fall last year. Following this the resident had been reviewed by allied health professional to support them. A risk assessment had also been developed to outline the control measures in place to reduce the risk of falls for this resident. However, as mentioned earlier in the report one resident who was a high risk of falls refused some supports from staff. While the staff team respected

this right, there was no evidence to support whether the implications of their refusal had been properly explained to them, particularly given the potential risk to the resident.

All staff had been provided with training in safeguarding adults. Of the staff met, they were aware of the procedures to follow in the event of an incident of abuse occurring in the centre. Residents were provided with education around staying safe.

Infection control measures were also in place. Staff had been provided with training in infection prevention control and donning and doffing of personal protective equipment (PPE). There were adequate supplies of PPE available in the centre. This was being used in line with national guidelines. For example; FFP2 masks were worn by staff. There were adequate hand-washing facilities and hand sanitising gels available and there were enhanced cleaning schedules in place. Staff were knowledgeable about what to do in the event that a staff or a resident was suspected of having COVID-19.

There were measures in place to ensure that both staff and residents were monitored for possible symptoms. The person in charge also conducted audits hand washing techniques with staff members to ensure they were washing their hands correctly. There was up to date guidance available for staff to keep them informed of any changes. Staff were aware of these changes also. Easy read information on COVID 19 was in place to support residents also.

As already stated earlier in this report there were a number of examples of where residents' rights were respected in the centre.

## Regulation 13: General welfare and development

While residents were supported to attend day services, one resident said that they would like to attend a day service more frequently.

Judgment: Substantially compliant

## Regulation 17: Premises

There were a number of updates required to the premises as identified through the providers own audits.

Some residents had hospital beds even though there was no identified need for these residents. This needed to be reviewed.

A couch in the sitting room had some minor tears in the cushions which could pose

a risk in relation to fire and/or infection control.

The dining area was sparsely decorated and while this was in line with one resident's needs, it needed to be reviewed to ensure that other residents' meal times experiences were pleasant.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

One resident who was a high risk of falls refused some supports from staff. While the staff team respected this right, there was no evidence to support whether the implications of their refusal had been properly explained to them, particularly given the potential risk to the resident.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

There were systems in place to prevent or manage an outbreak of COVID 19 in the centre.

Judgment: Compliant

## Regulation 28: Fire precautions

The inspector was not assured that residents could be safely evacuated from the centre in the event of a fire, particularly when a resident would not leave the building.

The fire evacuation plan did not guide practice.

It was not clear why a decision had been made not to install a carbon monoxide detector in the centre.

The inspector was not assured that both velux windows upstairs were suitable for rescue purposes.

Judgment: Not compliant

## Regulation 5: Individual assessment and personal plan

Improvements were required in one residents personal plan who had been assessed as requiring support with a specific type of infection. It was not clear on the day of the inspection whether this was still a need for the resident.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents were supported with their health care needs and had as required access to a range of allied health care professionals, to include GP, dietitian, occupational therapy and physiotherapy.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The rationale for the use of one restrictive practice was not clearly outlined.

The review of some restrictive practices used in the centre did not evidence if the restrictive practice was the least restrictive measure or whether other alternatives had been trialled.

Judgment: Substantially compliant

## Regulation 8: Protection

All staff had been provided with training in safeguarding adults. Of the staff met, they were aware of the procedures to follow in the event of an incident of abuse occurring in the centre. Residents were provided with education around staying safe.

Judgment: Compliant

## Regulation 9: Residents' rights

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| As already stated in this report there were a number of examples of where residents' rights were respected in the centre. |
| 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 (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 | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Substantially compliant |
| Regulation 17: Premises | Substantially 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 | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Substantially compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Praxis Care Mullingar OSV-0001915

## Inspection ID: MON-0032924

## Date of inspection: 01/02/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| Regulation Heading | Judgment |
|---|---|
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• The Registered Provider will ensure a 6 monthly judgement framework will be brought forward as a quality improvement review by the head of operations. Date: 30/03/22<br><br>• The Registered Provide will ensure an annual review is carried out by the head of operations and PIC of the service : Date 30/08/22<br><br>• The registered provider will ensure the plan of works identified by the provider to be completed in their entirety. Date 30/9/2022<br><br>• The Registered Provider has returned a Provider reassurance plan relating to Fire Precautions and Governance & Management as requested. Date: 25/02/2022<br><br>• The Registered Provider has ensured a full review of Restrictive Practices has taken place to ensure they are the least restrictive measure and that alternatives have been considered. Date: 23/04/22<br><br>• The Registered Provider will ensure that Individual plans are reviewed Monthly by the Head of Operations to ensure they accurately reflect the residents current assessed needs. Date: 30/03/22 | |
| Regulation 13: General welfare and development | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 13: General welfare and development:<br>The registered provider shall ensure:<br>• A review of day service provision was discussed with the resident who requested more frequent attendance. Specific actions were agreed and are being followed which the service user is satisfied with. Date: 03/02/2022<br><br>• The provision of day service will be discussed and reviewed monthly at key working meetings. 28/02/2022<br><br>• The PIC will ensure any day service provision requirements outside of current arrangement are discussed with MDT to agree appropriate actions for Service users. 28/02/2022 | |
| Regulation 17: Premises | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>• The registered provider shall ensure that a review of all residents with hospital beds will be carried out through OT review. Date 28/3/22<br><br>• The PIC has ensured a new couch has been purchased to replace the couch in the sitting room so there is no risk to fire and or/ infection control. Date: 03/03/2022<br><br>• The PIC has ensured key working meetings with service users have been held to ensure the décor of the dining room is pleasant for all residents and appropriate to their needs. Work to decorate dining room will be completed. Date 31/05/22<br><br>• The registered provider will ensure the plan of works identified by the provider to be completed in their entirety. Date 30/9/2022<br><br>· Substantive works will be scheduled with the following time lines:<br>· Painting of the property 31/5/22<br>· Kitchen refurbishment 31/5/22<br>· Floors 31/7/22<br>· Bathrooms 30/9/22 | |
| Regulation 26: Risk management procedures | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 26: Risk management procedures:<br>The registered provider will ensure that:<br><br>• A Key working meeting was held to discuss the resident's refusal to use supports offered and the implications of a fall for the resident. Date 02/02/22<br><br>• The PIC will ensure the implications of falls are discussed with resident on a monthly basis. Date: 02/02/2022<br><br>• The PIC met with allied professional ID Psychiatric nurse to discuss the associated risk regarding falls and management of same. Complete 24/2/22<br><br>• The PIC discussed with family of resident the associated risk of falls and management of same. Complete 25/2/22<br><br>• The PIC will link in with coagulation specialist nurse to discuss and review risk management of falls. Any recommendations from this will be updated in the residents plan's. Date 30/3/22 | |
| Regulation 28: Fire precautions | Not Compliant |
| Outline how you are going to come into compliance with Regulation 28: Fire precautions:<br>The registered provider shall ensure that:<br><br>1. The Registered Provider has reviewed all Peep Plans and Fire Evacuation Plan have been reviewed and updated by PIC. Date: 7/2/22<br><br>2. The Registered provider has ensured that the Head of Fire Safety has reviewed all updated peeps plans and fire risk assessment. Date: 25/2/22<br><br>3. The Registered Provider has ensured the evacuation plan has been reviewed and updated by the Head of Fire Safety to ensure it provides adequate information, instruction and guidance on Fire Emergency Evacuation. Date: 03/02/2022<br><br>4. The Registered Provider has reviewed, and can assure the regulator that PEEP's are in place for all residents within the centre and, so far as is reasonably practicable, is confident that the actions contained therein will ensure the safety of all residents. Date: 17/2/22<br><br>5. The Registered Provider has ensured all PEEPs specifically appropriate to residents needs will continue to be reviewed at least annually – or earlier in the event of any change in circumstances or in relation to a resident's needs. Date: 17/2/22 | |

6. The Registered Provider has reviewed where there is potential for any resident not to evacuate, the Registered Provider is assured that additional mitigating actions are in place, recorded appropriately and will so far as is reasonably practicable ensure the safety of residents. Date:17/2/22

7. The Registered Provider is assured that appropriate staffing levels are in place in the centre to safely meet the assessed needs of the residents. Date: 3/2/2022

8. The Registered Provider has specifically reviewed our fire safety and emergency evacuation systems in this centre in order to assure the safety and consistency of approach towards all residents in relation to their individually assessed needs and these systems are monitored regularly. Date: 17/2/22

9. The Registered Provider will ensure a Building Surveyor and Head of Property reviews the evacuation points from this centre including the velux windows to ensure building control compliance, and any action culminating from said visit will be completed. Date: 16/3/22

10. The Registered Provider has confirmed with the Head of Fire Safety that the velux windows are standard specification velux windows. These windows were not intended for the purpose of evacuation, but for the purpose of rescue, this requires review and all actions will be completed from consultation input. Date:6/04/22

11. The Registered Provider will commission a fire engineer to review this centre including all aspects of fire escape. Date: 6/4/2022

12. The Registered Provider will ensure if these velux windows are not compliant we will engage a fire engineer to confirm the changes required and we will address any areas of non-compliances and ensure any material alterations required are completed fully by the Registered Provider. Date: 6/7/2022

13. The Registered Provider had previously not installed carbon monoxide monitors in the centre as there were no fossil fuel appliances located internally within the centre. The boiler house is located externally, i.e. attached to the rear external wall of the dwelling, and the boiler house is fully enclosed in fire resistant structure and there are no opportunities for carbon monoxide emissions to enter the dwelling.

14. The Registered Provider has now installed 3 wireless linked CO monitors in the property – 1 x boiler room; 1 x ground floor, 1 x 1st Floor. The first testing was recorded on 03.03.2022

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| Regulation 5: Individual assessment and personal plan | Substantially Compliant |

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| Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:<br>• The Registered Provider has ensured that a review on one residents needs relating to a specific type of infection have been reviewed and it has been agreed that risk of infections is no longer an assessed need for this resident. Date: 04/02/2022<br><br>• The Person in Charge has ensured the Care records for this resident have been updated to reflect same. Date: 04/02/2022 | |
| Regulation 7: Positive behavioural support | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>• The Registered Provider has ensured a full review of Restrictive Practices has taken place to ensure they are the least restrictive measure and that alternatives have been considered. Date: 14/2/22<br><br>• The PIC has updated the Restrictive Practice Register to ensure the rationale and other considerations are clearly recorded. Date: 14/2/22<br><br>• The PIC will ensure that the Positive Behaviour Support Consultant will complete a review of all restrictions and update PBS Plan with any changes. Date: 07/3/2022<br><br>• The PIC will ensure restrictive practices are reviewed quarterly. Date: 14/5/22<br><br>• The PIC along with Head of operations will review all restrictive practices for this centre at the Restrictive Practice Review Committee. Date: 23/8/22 | |

## 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 13(2)(a) | The registered provider shall provide the following for residents; access to facilities for occupation and recreation. | Substantially Compliant | Yellow | 03/02/2022 |
| Regulation 17(1)(a) | The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents. | Substantially Compliant | Yellow | 31/03/2022 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 30/09/2022 |
| Regulation | The registered | Substantially | Yellow | 30/08/2022 |

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| 23(1)(c) | 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. | Compliant | | |
| 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 | 30/03/2022 |
| Regulation 28(1) | The registered provider shall ensure that effective fire safety management systems are in place. | Not Compliant | Orange | 06/07/2022 |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Not Compliant | Orange | 25/02/2022 |
| Regulation 05(6)(d) | The person in charge shall ensure that the personal plan is | Substantially Compliant | Yellow | 04/02/2022 |

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| | the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments. | | | |
| Regulation 07(5)(c) | The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used. | Substantially Compliant | Yellow | 23/08/2022 |