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:	Ravenswell
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	27 April 2022
Centre ID:	OSV-0003581
Fieldwork ID:	MON-0027936

About the designated centre

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

Ravenswell is a designated centre operated by St John of God located in town in north Co. Wicklow. Residents have access to a range of community based facilities to include cafes, hotels, pubs, parks, shops and shopping centres. The centre is situated within a large building on a congregated campus. The designated centre comprises of two separate residential units within the building. Ravenswell provides residential and respite services to eleven adults (male and female) with disabilities. Each resident has their own bedroom decorated to their individual assessed needs and personal preferences. Communal areas within the designated centre include sitting rooms, dining areas, kitchens and a relaxation room. The provider has identified the premises is not suited for their stated purpose and has plans to de-congregate the centre and support residents to transition to community based houses in a phased transition process. The staff team consists of a person in charge, programme manager, social care leader and a team of qualified social care professionals and nurses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
Wednesday 27 April 2022	10:15hrs to 16:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to inform a registration renewal recommendation for this designated centre.

The inspector wore a face covering and physical distancing measures were implemented as much as possible with residents, staff and family members during the course of the inspection. The inspector also respected resident's choice to engage with them or not during the course of the inspection at all times.

The inspector greeted residents present in the centre during the course of the inspection. Residents the inspector met were mostly unable to provide verbal feedback about their experience of living in the centre. One resident did verbally interact with the inspector which was about the centre's pet therapy dog and the inspector's pet dogs. The resident was observed to be spending time in their bedroom and appeared happy and content. The inspector observed staff interacting with residents in a pleasant manner.

Residents living in this designated centre had varied complex needs in the areas of behaviour supports, management of self-injurious behaviours and some physical health needs. Some residents required mobility supports while others were independently mobile.

The centre was made up of two different living areas, located within a larger building. The provider had endeavoured to make the living arrangements for residents as homely and personalised as possible throughout.

Each resident bedroom was decorated and individualised to reflect their personality but also with due regard to their assessed needs. Residents had access to a secure outdoor garden area and throughout the premises was well ventilated and bright.

Residents were also provided with separate living room spaces and a functioning kitchen area where their meals were prepared and modified as required. Staff spoken with were able to demonstrate a good understanding of each resident's modified consistency diet and discussed the consistency the meals provided and how they prepared the meals in this manner.

The inspector took the opportunity to meet with the family of resident and seek feedback about the service their loved one received. Overall, the family were extremely happy with the care their adult child received. They were complementary of the person-centred approach to care and support for residents living in the centre.

The family also discussed visiting arrangements for the centre. They said they always felt very welcome, they were very appreciative of the open and transparent way staff and management communicated with them and they were included in all

decision making and about any changes to their adult child's care and support. They were also invited to attend person-centred planning meetings which they understood were very important and they were happy to be part of those meetings.

They had also been informed and consulted about the planned de-congregation for the centre and were being informed in a consistent manner of any updates in this regard.They mentioned that they knew who they could raise any complaint or issue with but had not had a need to do so as the care was to a very high standard and they were very appreciative and happy their adult child lived in the centre.

Overall, the inspector found a good level of compliance on this inspection. Residents were in receipt of a good standard of care and support. The overall premises layout, location and design was institutional in nature despite the provider's efforts to make the premises as homely and person-centred as possible.

However, on this inspection, it was noted that the provider had made considerable progress in their de-congregation plan for the centre with two residents identified to transition from the centre to community based homes in the coming months and a further number of residents due to transition to another community residential home some time thereafter.

It was noted there were comprehensive planning arrangements in place to support and oversee the transition of residents from the centre with due consideration given to the compatibility of residents, the staffing arrangements, the premises layout and design of the newly proposed centre. Residents, families and resident representatives were also heavily involved in the transition process, ensuring residents were fully involved and considered in all aspects of the transition planning.

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 affected the quality and safety of the service being delivered.

Capacity and capability

The governance and management arrangements within the centre ensured appropriate resources were available to operate a safe and effective service.

There was a statement of purpose in place that clearly described the model of care and support delivered to residents in the centre. It contained all the information set out in Schedule 1 of the regulations.

There was a suitably qualified and experienced person in charge that met the requirements of Regulation 14 in relation to management experience and qualifications. They were responsible for this centre and one other designated centre located in the same building. The provider had put in place governance arrangements to support their regulatory management remit and a social care

leader formed part of the management team for the centre.

There were clearly defined management structures which identified the lines of authority and accountability within the centre. Staff reported to the social care leader, who was based within the centre, they in turn reported to the person in charge.

There were arrangements in place to monitor the quality of care and support in the centre. The person in charge and social care leader carried out various review audits in the centre on key areas related to the quality and safety of care provided to residents.

The person in charge had created an audit schedule for the year that reviewed key quality indicators, for example, medication management, residents' finances, personal planning reviews, staff training, environmental and infection control audits and reviews of COVID-19 arrangements and contingency planning.

This auditing schedule and practice ensured a high level of compliance with the regulations as it complemented the provider-led regulatory audit framework by way of six-monthly unannounced visits and an annual report.

The provider had ensured that an unannounced visit to the centre was completed as per the Regulations. Where areas for improvement were identified within these audits, plans were put in place to drive improvement. This process was monitored using a quality enhancement plan. Additionally, the provider had also ensured an annual review of quality and care was completed for the previous year.

Staffing arrangements at the centre broadly reflected what was outlined in the statement of purpose. From a review of the roster, it was evident that there was an appropriate skill-mix of staff employed at the centre. The person in charge had ensured that there was both a planned and actual roster maintained.

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, fire safety, infection control and manual handling. The person in charge maintained a register of what training was completed and what was due.

Staff were also provided with training in additional areas which were closely aligned to the assessed needs of residents living in the centre, for example, staff had received training in dysphagia management with face-to-face training facilitated with a speech and language therapist, all staff had received training in management of behaviours that challenge, with some staff also completed a more comprehensive course in positive behaviour support.

A review of supervision records noted that staff were supervised and these records detailed a good level of staffing support. There was a clear supervision process in place and supervision was planned throughout the year.

The provider's complaints policy was in place and at the time of inspection under review, there was evidence of it's implementation in the centre. The person in

charge maintained a copy of all logged formal and informal complaints in the centre.

The inspector reviewed a sample of complaints that had been logged and noted that there was overall good general adherence to the procedural steps of the provider's complaints policy. In addition, there had been care made to note the complainant's overall satisfaction with the outcome of the compliant and a documented appeals process in the provider's policy also. An easy read complaints policy was in place and a complaint's leaflet was also available if required.

The provider had submitted a full and complete application to renew registration of this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted a full and complete application to renew registration of this designated centre.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the centre that met the matters of Regulation 14.

They were responsible for three designated centres.

The provider had put supervision and governance arrangements in place to support the person in charge in their regulatory management role by appointing a supervisor to operationally day-to-day manage the designated centre.

A social care leader worked in this centre in the role of supervisor and reported to the person in charge.

Judgment: Compliant

Regulation 15: Staffing

Staffing arrangements at the centre broadly reflected what was outlined in the statement of purpose.

The person in charge had ensured that there was both a planned and actual roster

maintained.

From a review of the roster, it was evident that there was an appropriate skill-mix of staff employed at the centre.

There were adequate nursing skill-mix numbers in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

There was a schedule of staff training in place that covered key areas such as safeguarding vulnerable adults, fire safety, infection control and manual handling. Staff were also provided with additional training to meet the assessed needs of residents, for example, training in dysphagia management, infection control and positive behaviour support.

The person in charge maintained a register of what training was completed and what was due.

Staff had received supervision from their line manager over the year and there were additional scheduled supervision dates scheduled for the remainder of the year.

The Person in charge provided clinical governance and supervision arrangements in relation to nursing care and practices in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The provider had ensured a six-monthly provider led audits for the centre had been completed for the previous year and were available for review during the course of the inspection.

These were noted to be of a good quality and comprehensive in scope with provision of an action plan for the person in charge to address.

The provider had completed an annual report for the centre for 2020.

The provider had ensured appropriate operational management oversight arrangements were in place in the absence of the person in charge by appointing a social care leader to manage the service in their absence with additional oversight by a senior services manager.

The person in charge had created an audit schedule for the year that reviewed key quality indicators.

This auditing schedule and practice ensured a high level of compliance with the regulations as it complemented the provider-led regulatory audit framework by way of six-monthly unannounced visits and an annual report.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider had ensure the statement of purpose for the centre met the matters of Schedule 1 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider's complaints policy was in place and at the time of inspection under review, there was evidence of it's implementation in the centre.

The person in charge maintained a copy of all logged formal and informal complaints in the centre which was available to review and maintained in the centre.

The inspector reviewed a sample of complaints that had been logged and noted that there was overall good general adherence to the procedural steps of the provider's complaints policy.

In addition, there had been care made to note the complainant's overall satisfaction with the outcome of the compliant and a documented appeals process in the provider's policy also.

An easy read complaints policy was in place and a complaint's leaflet was also available if required.

Family members spoken with said they knew who to make a complaint to, they were satisfied with the communication they received from the centre about the care and support received by their adult child and felt they could raise concerns or ask questions if they needed to.

Judgment: Compliant

Quality and safety

Residents living in the centre were in receipt of a good quality service. A good level of compliance was found on this inspection. Some minor improvement was required in relation to fire evacuation measures in the centre to ensure, where possible, the most optimum arrangement was in place.

Overall, it was demonstrated fire safety precautions were of a good standard in the designated centre.

Emergency lighting was located at key areas, fire servicing checks were up-to-date and fire evacuation drills were carried out with good frequency and evaluated different evacuation scenarios. Staff had received up-to-date fire safety training with refresher training also provided. Fire drills took place on a regular basis and examined both day and night time evacuation simulations.

The designated centre was located in a larger building that contained one other designated centre and office areas on the first floor of the building. The provider had put arrangements in place to ensure a centralised fire alarm system was in place with repeater panel alarms located in the designated centres located in the building. This ensured when the alarm sounded within the overall building, staff could locate the source of the alarm by checking the fire panel located within their own designated centre and not have to travel to a centralised panel a further distance away.

Fire servicing records were maintained and showed that fire extinguishers, emergency lighting and fire alarm servicing was carried out for the entire building at each quarter. This ensured the servicing checks for the entire building were taken into consideration at each time of servicing. Localised daily checks in the designated centre were carried out by staff and maintained as a record in the designated centre.

The inspector observed there were no thumb turn provisions in place on exit doors in either of the two residential units that made up the centre. The inspector also noted that a review, by a fire safety engineer, in 2021, had also recommended the installation of thumb turn door openers to be fitted in the centre.

While it was recognised some residents presented with personal risk concerns in relation to absconding, it was not demonstrated that a risk evaluation in this context, had been carried out to identify what exit doors posed a risk of absconding with the installation of a thumb turn and what doors did not. This required improvement to ensure the most optimum fire evacuation measures were in place where possible.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for

staffing and isolation of residents if required. The provider and person in charge had ensured that all staff were made aware of public health guidance and any changes in procedure relating to this.

There was a folder with information on COVID-19 infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment was in good supply and hand washing facilities were available in the centre with a good supply of hand soap and alcohol hand gels available also. Each staff member and resident had their temperature checked daily as a further precaution.

Staff were observed to wear face coverings in line with public health guidelines, throughout the course of the inspection.

The provider had also demonstrated learning and improvement organisationally in the wider context of COVID-19 and there were notable enhanced standard infection control precautions and systems in place in the centre. The person in charge had instated a sharps management risk assessment and protocol, a laundry management procedure in line with infection control standards, the sourcing of a spills kit and also there was an enhanced infection control audit arrangement being implemented which reviewed infection control standard management in the centre.

he person in charge and provider continued to make positive efforts to enhance the homeliness of the centre. For example, residents' bedrooms were individualised as far as possible and their were pleasant decorations in the common areas. Bathing and toilet facilities were well maintained and provided residents with adequate space and assistive equipment to meet their assessed needs. While these facilities were in place, overall the premises still presented as institutional in layout, location and design and constituted a congregated setting.

The provider had a long standing plan to transition residents to a more suitable community based residential homes that could meet residents' assessed. Previously, this plan had been delayed, however, on this inspection the plan had progressed well and two residents were identified to transition from the centre as part of the provider's overall de-congregation plan.

Some residents required modified consistency meal provisions. As discussed, staff spoken with demonstrated a good understanding of residents' nutritional needs and their modified consistency meal requirements. Staff training had been provided and kitchens, in both residential units, were observed to be clean, well maintained and adequately stocked with fresh, frozen and dry goods with additional condiments for preparing meals.

Each resident had an associated modified consistency meal plan in place, a record of their meal preferences and preferred tastes. Some residents also required support and nutritional review by dietitian allied professionals. Up-to-date nutritional care planning was in place for those residents and it was noted residents had received regular review in this regard.

Some residents living in this centre required positive behaviour supports. Where this

need had been identified, residents had an up-to-date positive behaviour support plan in place that had been drawn up and regularly reviewed by an appropriately qualified allied professional. Staff had received training in breakaway techniques and management and response to behaviours that challenge. Some staff had also completed additional more intensive training in positive behaviour support.

There were a number of restrictive practices implemented in the centre to manage and mitigate personal risks for some residents. There was a due recognition that some aspects of the premises could not fully support the least restrictive environment. The provider's human rights and equality committee had reviewed a number of restrictive practices in the centre.

It was noted that this committee provided a healthy challenge with regards to some of the restrictive practices that were implemented in the centre, requiring the person in charge and staff to consistently review such practices and establish lesser restrictive arrangements and keep these restrictions under continuous review. This was a positive arrangement in the area of restrictive practice and ensured a robust arrangement and oversight was in place.

Regulation 17: Premises

Overall, the provider had made a number of arrangements and premises enhancements to make the centre as homely and person-centred as possible.

However, overall the location, design and layout of the premises continued to present as institutional and the centre continued to constitute a congregated setting arrangement.

The provider however, had made considerable progress on their de-congregation plan for the centre which would see some residents transition out of the centre this year with further transitions planned the following year.

The inspector observed some areas of the centre that required refurbishment or improvement.

- The couches in both residential unit living room areas were observed to be worn, with one couch considerably more in need of replacement, for example, ripped leather and marks of wear and tear evident.
- Throughout a number of areas required touch ups or repainting of marked areas.
- A number of doors and skirting were observed to be scuffed and worn looking.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents' assessed food and nutritional needs were well managed in the centre.

Fresh and dry food was stored in hygienic conditions with open dates documented and labelled on foods stored in the fridge.

Staff were trained in how to modify meals and were knowledgeable of the modified consistency meal and fluid provision for residents.

The provider had made arrangements for equipment ,for modifying meals, was available in the centre.

Residents' nutritional needs were reviewed by dietetic allied professionals with up-to-date recommendations in place.

Residents meals were planned ahead of time, with a visual meal planner in place in each kitchen area and a copy of each residents' nutritional and dysphagia plan readily available in each kitchen of the centre, for staff to refer to, if required.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

There were comprehensive planning arrangements in place to support and oversee the transition of residents from the centre with due consideration given to the compatibility of residents, the staffing arrangements, the premises layout and design of the newly proposed centre. Residents, families and resident representatives were also heavily involved in the transition process, ensuring residents were fully involved and considered in all aspects of the transition planning.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19.

There was evidence of ongoing reviews of the risks associated with COVID-19 with contingency plans in place for staffing and isolation of residents if required.

The provider and person in charge had ensured that all staff were made aware of

public health guidance and any changes in procedure relating to this.

The provider had enhanced the infection control audit arrangements within the organisation with the introduction of a revised infection control audit template which encompassed the review of a number of standard precaution areas in the wider context of COVID-19.

The person in charge had established a number of infection control procedures for the designated centre in relation to laundry management, sharps management and establishing enhanced cleaning regimes of high touch areas.

All staff were observed to wear face coverings in line with the latest public health guidelines. Alcohol hand gel was made available at key areas within the centre and a staff symptom check was also carried out each shift.

Staff had received a good range of enhanced infection control training which also reviewed the areas of standard precautions as well as hand hygiene, donning and doffing of PPE and Covid-19.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, it was demonstrated fire safety precautions were of a good standard in the designated centre.

The designated centre was located in a larger building that contained one other designated centre and office areas on the first floor of the building. The provider had put arrangements in place to ensure a centralised fire alarm system was in place with repeater panel alarms located in the designated centres located in the building. This ensured when the alarm sounded within the overall building, staff could locate the source of the alarm by checking the fire panel located within their own designated centre and not have to travel to a centralised panel a further distance away.

Fire servicing records were maintained and showed that fire extinguishers, emergency lighting and fire alarm servicing was carried out for the entire building at each quarter.

Localised daily checks in the designated centre were carried out by staff and maintained as a record in the designated centre.

The inspector observed there were no thumb turn provisions in place on exit doors in either of the two residential units that made up the centre. The inspector also noted that a review, by a fire safety engineer, in 2021, had also recommended the installation of thumb turn door openers to be fitted in the centre.

While it was recognised some residents presented with personal risk concerns in relation to absconding, it was not demonstrated that a risk evaluation in this context, had been carried out to identify what exit doors posed a risk of absconding with the installation of a thumb turn and what doors did not.

This required improvement to ensure the most optimum fire evacuation measures were in place, where possible, with due consideration for any additional personal risks of residents, for example, absconding risks.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Some residents living in this centre required positive behaviour supports.

Where this need had been identified, residents had an up-to-date positive behaviour support plan in place that had been drawn up and regularly reviewed by an appropriately qualified allied professional.

Staff had received training in breakaway techniques and management and response to behaviours that challenge. Some staff had also completed additional more intensive training in positive behaviour support.

The provider's human rights and equality committee had reviewed a number of restrictive practices in the centre.

It was noted that this committee provided a healthy challenge with regards to some of the restrictive practices that were implemented in the centre, requiring the person in charge and staff to consistently review such practices and establish lesser restrictive arrangements and keep these restrictions under continuous review.

This was a positive arrangement in the area of restrictive practice governance and ensured a robust arrangement and oversight was in place.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Ravenswell OSV-0003581

Inspection ID: MON-0027936

Date of inspection: 27/04/2022

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • New couches have been ordered to replace the old ones in both apartments. • Maintenance personnel contacted to address touch ups and areas that need re-painting including scuffed doors and skirting boards.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Management have assessed exit doors that do not have thumb locks to determine which doors need them and which do not. • A risk assessment has been completed for the doors that cannot have thumb locks installed due to the risk of absconsion. This restriction will remain under review.	

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 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	04/07/2022
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	30/06/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	24/05/2022