Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Mixed).

Issued by the Chief Inspector

Name of designated centre:	Donabate Respite 2
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	11 May 2022
Centre ID:	OSV-0002388
Fieldwork ID:	MON-0028278

About the designated centre

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

Donabate Respite 2 is a designated centre operated by St. Michael's House. The centre comprises of one six bedroom purpose built premises. This respite service is registered as a mixed designated centre. The centre predominantly provides respite services for adults. The registration conditions for the centre however, allows the provider to provide respite services for children should the need arise and only when no adults are residing in the centre. The centre is located in a suburban town and is in close proximity to a range of local amenities and public transport. There is a small garden to the rear of the centre. Throughout the centre large communal space is provided with comfortable seating options and two living room spaces provided with TVs. Residents are provided with a private bedroom space during their stay and accessible toilet and bathing facilities. The centre is managed by a person in charge who reports to a senior manager. The staff team consists of nurses and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 11 May 2022	09:00hrs to 17:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

In line with public health guidance, the inspector wore a face mask and maintained physical distancing as much as possible during interactions with residents and staff. The inspector had the opportunity to meet with all of the residents on the day of inspection. Some chose to interact with the inspector while others preferred to continue with their activities and interests. Three residents from the last respite break had also completed questionnaires for the inspector to review. The inspector used observations, discussions with residents and key staff and a review of documentation to form judgments on the quality of residents' lives in the designated centre. Overall, the inspector found that the designated centre was providing a comfortable and enjoyable respite service to the residents who accessed it.

The designated centre was located on a small campus-based setting close to a suburban village. There was easy access to local recreational facilities including the cinema, bowling, shops and restaurants for those residents who wished to access these. The centre was clean and bright and was generally well maintained. Residents had access to their own bedrooms for the duration of their stay, many of which were furnished with televisions. Residents also had access to a large kitchen, sitting room and conservatory. A back garden with a trampoline and seating was available for relaxation and recreation.

The residents appeared comfortable and relaxed in the designated centre. On arrival from day service, residents were observed to greet the staff and immediately went to their preferred area of the house. Some residents chose to make cups of tea and were assisted in doing so by staff. Other residents accessed the back garden and were supported by staff to put on sun cream and to have refreshments outside as was their preference. Residents were clearly familiar with the designated centre and with the staff. A review of resident questionnaires showed that residents enjoyed attending the designated centre and would like to attend more frequently if possible.

The inspector saw staff interacting with residents in a gentle and respectful manner. Staff used Lámh and communicated with residents in line with their communication plans. Staff were seen to be attentive and were responsive to residents' communications. A planning meeting was held with residents at the commencement of their respite break and activities for the break were discussed.

Overall, the inspector found that residents attending respite in this centre were supported to enjoy a good quality respite break which was delivered in a person-centred manner and was respectful of their choices.

The next two sections of the report will present the findings of the inspection in relation to the governance and management arrangements in place and how these impacted on the quality and safety of care in the designated centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and to contribute to the decision-making process for the renewal of the centre's registration. The inspector found that this service had the capacity and capability to deliver a good quality, person-centred service which met the requirements of the regulations in many areas.

The provider had mechanisms in place to support them in their oversight of the designated centre. Regular audits were completed which identified issues and set out clear, time-bound plans to address these. Audits completed in this designated centre included an annual review of the quality and safety of care of the service, six -monthly unannounced visits and quarterly health and safety checklists. The inspector saw that the six monthly audits showed progression of actions in a timely manner. One area for improvement, which had been identified in previous HIQA reports and through the provider's own audits was the oversight of the residents' personal plans. The designated centre provided respite care for over 110 residents at the time of inspection. This created significant work for the person in charge in ensuring that these plans were reviewed and updated annually, or as frequently as required. In this regard, the provider had enhanced the systems in place to support oversight of this process. The service had access to a respite liaison nurse who supported the person in charge in having oversight of personal plans. This will be discussed further in the quality and safety section of the report.

The centre was run by a full-time person in charge. The person in charge had been in their position for several years and consequently knew the residents and the service needs well. They were employed in a supernumerary position and had no other designated centres under their remit. The person in charge was in receipt of regular supervision and support from the service manager.

A planned and actual roster was maintained for the designated centre. The inspector saw that the number, qualifications and skill -mix of staff were appropriate to meet the needs of the residents. Nursing care was available to residents as per their assessed needs. The service was operating with one whole time equivalent (WTE) vacancy at the time of inspection. Where there were gaps in the roster, these were filled by a small panel of regular relief and agency staff.

There was generally a high level of mandatory and refresher training maintained in the designated centre. All staff were up -to -date in key training areas including fire safety, safeguarding, COVID-19 and positive behaviour support. Staff had also received training specific to meet the assessed needs of the residents including feeding, eating, drinking and swallowing (FEDS) and fire evacuation aids such as evacuation chairs. There was a delay in staff receiving refresher training in environmental first aid with 11 out of 16 staff requiring refresher training in this

area. This delay was attributed to the requirement for this training to be delivered face -to -face and, therefore, a backlog had developed due to COVID-19 restrictions.

A supervision schedule and supervision records of all staff was maintained in the designated centre. The inspector saw that staff were in receipt of regular, quality supervision which covered topics relevant to service provision and professional development. Staff reported to the inspector that they felt supported in their roles and were comfortable in raising concerns or issues. Staff reported that they felt the provider responded in a timely manner to concerns raised by staff.

An up-to-date statement of purpose was available in the designated centre. This was reviewed by the inspector and was found to contain most of the information as required by Schedule 1 of the regulations. However, further information was required on the arrangements in place to review, develop and update residents' personal plans.

A full and satisfactory application for renewal of the designated centre's certificate of registration was submitted to the Chief Inspector within the time frame required. At the time of writing the report, the provider had set out in their application that they intended for the centre to be registered for use by adults only during the forthcoming cycle of registration.

Registration Regulation 5: Application for registration or renewal of registration

A full and satisfactory application to renew the registration of the designated centre was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 14: Persons in charge

There was a suitably qualified and experienced person in charge who was employed in a full-time capacity. The person in charge had mechanisms in place to support them in their role. They had been employed in the service for several years and knew the residents and their assessed needs well.

Judgment: Compliant

Regulation 15: Staffing

A planned and actual roster was maintained for the designated centre. A review of the roster identified that the staffing levels and skill mix were adequate to meet the needs of the residents and were in line with the statement of purpose.

There was one WTE vacancy in the centre at the time of inspection. Gaps in the roster were being filled by a small panel of regular relief and agency staff. This supported continuity of care for residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a high level of mandatory and refresher training maintained in the designated centre. All staff were up-to-date with the majority of mandatory training required. There was one training need identified which was in Environmental First Aid and 11 staff required refresher training in this area.

Staff were in receipt of regular quality supervision, the frequency of which was in line with the provider's policy. Staff reported feeling supported in their roles.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had effective systems in place to ensure oversight of the designated centre. A series of audits were completed which identified actions and comprehensive, time-bound plans. There was evidence that actions were addressed by a responsible person in a timely manner. Staff were supported and performance managed. Staff reported that they were facilitated to raise concerns regarding the quality and safety of the service and that any concerns were responded to in a timely manner by the provider.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed and found to contain most of the information as required by Schedule 1 of the regulations. However, further information was required on the arrangements in place for dealing with reviews and

the development of residents' personal plans.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre. Overall, the inspector found that the day-to-day practice within this centre was ensuring that residents were in receipt of a good quality service. However, a review of the fire evacuation procedures was required to ensure that all residents could be evacuated in a timely manner.

The provider had made arrangements to detect, contain and extinguish fires in the designated centre. However, the measures to evacuate residents required review. The inspector saw on a walk -around of the centre that the side exit doors were locked and that the side gates beyond these doors were padlocked. A key to open one of these side doors, as well as the keys to open the padlocked gates, were not readily available. The inspector was informed that the door key had been removed due to an identified risk of a resident absconding. However, the risk that this posed to a timely evacuation of residents in the event of a fire had not been assessed. It was unclear why the final exit side doors were not push bar exits as the absconding risk had been addressed by the locked side gates and enhanced supervision levels.

The keys to the padlocked side gates were stored in an office and were not routinely carried by staff. This had also not been risk assessed. The inspector was assured on the day of inspection that staff on duty would routinely carry these keys until this risk had been reviewed.

The inspector also reviewed the centre’s fire drills and found that, while fire drills were held regularly, these often did not reflect the actual night-time resident and staff numbers. Two night-time drills in late 2021 had three staff participating in them. However the centre usually only had two staff on duty by night. Most fire drills also evacuated to the back garden and did not provide for arrangements for residents to evacuate via the padlocked side gate to an area of safety at the front of the house.

The site evacuation plan required further information. For example, it did not detail where the assembly point was or what the night-time arrangements would be if a full site evacuation was required. The centre was reliant on a local community centre for day-time site evacuations however this would most likely be unavailable by night.

The designated centre was a respite service providing support to over 110 service users. A previous inspection finding was a deficit in the provider's audits where several residents' assessments of need and personal plans were not updated regularly. This was attributed to large volume of residents accessing this service.

The inspector found that the provider was in the process of implementing systems in order to address this issue at the time of inspection. A keyworking system had been introduced, with each staff having responsibility for updating a certain number of residents' personal plans. The inspector was informed that a respite checklist was completed with residents' representatives prior to their respite break. This checklist was used to screen for any recent changes to residents' assessed needs.

The designated centre also had access to a respite liaison nurse. The respite liaison nurse supported keyworkers in updating residents' personal plans by liaising with external services regarding changes to assessed needs. The respite liaison nurse and person in charge had also compiled a comprehensive database of residents in order to track when changes to residents' assessments of need and personal plans were required. The inspector reviewed this database, as well as a selection of resident files, on the day of inspection. It was found that, while all residents had an assessment of need and personal plans available, some of these were out-of-date and required updating. The inspector was assured by the person in charge that, with the new structures in place, these would be updated in a timely manner.

Positive behaviour support plans were on file for those residents who required them. These plans included information to support staff in respite to assist residents in managing their behaviour. Risk assessments were on file for residents who presented with particular risks in the area of behaviour. Risk assessments set out control measures to support staff in managing behaviour that was challenging. All staff had received and were up-to-date in training in challenging behaviour. Restrictive practices were logged and notified accordingly and had been reviewed by the provider's rights committee.

Staff had also completed training in safeguarding vulnerable adults and Children First. Staff were knowledgeable regarding their roles and responsibilities in safeguarding the residents who accessed respite. Where allegations of abuse had occurred, these were investigated and notified in line with statutory requirements. Resident files also had an intimate care plan where required. Intimate care plans were written in person-centred language and provided information on resident choices and preferences in relation to their intimate care needs.

The inspector saw that residents' files contained information, through their behaviour support and communication plans, on their preferred mode of communication. Residents accessing this designated centre used a range of communication modes including objects of reference, Lámh, picture exchange communication systems (PECS) and body language. Staff spoken with were knowledgeable regarding residents' communication systems as described in their personal plans. The inspector also saw staff interacting with residents using their preferred mode of communication including Lámh.

A residents' guide was available in the centre for residents to access. This guide provided information to residents on the services and facilities provided during their stay, the terms and conditions of residency, the arrangements for residents to be involved in the running of the centre, the complaints procedure and visiting

arrangements as well as the process for accessing inspection reports.

The designated centre was found to be bright and spacious. It was clean and generally well maintained aside from the flooring in two resident bedrooms which was due to be replaced later on during the month of the inspection. The centre was furnished with equipment to meet the residents' assessed needs including ceiling tracking hoists. Each resident had access to their own bedroom and some of these bedrooms were furnished with televisions. Residents also had access to a large sitting room, conservatory and kitchen area. The centre had a garden which was furnished with equipment for relaxation and play. The inspector saw that residents appeared comfortable and relaxed in the respite house. They were familiar with the layout and on arrival from day service, they immediately went to their preferred areas of the house to make tea, relax in the conservatory or spend time in the garden.

The inspector saw that the fridge and kitchen were stocked with wholesome and nutritious foods. It was not clear however, how residents were consulted with in relation to the meal choices while on their respite break. A residents' meeting was held during which activities were planned however a menu was not reviewed or discussed. Several residents had feeding, eating, drinking and swallowing (FEDS) support plans on file. Staff were aware of these plans and all staff had completed training in FEDS. However, the inspector saw that there was inconsistency among staff regarding the process for thickening fluids. Staff were noted to consult with each other regarding the appropriate fluid consistency rather than performing a recommended test to determine if the fluid was the correct consistency.

The provider had several measures in place to support good infection prevention and control practices in the centre. All staff were seen to be wearing appropriate personal protective equipment (PPE) and were socially distancing where possible. Temperature checks were taken of residents as a baseline measurement when they arrived to the centre however there was no routine monitoring of symptoms for COVID-19 among residents, as advised by current public health guidance. Staff had completed training in IPC and were knowledgeable regarding their roles and responsibilities in protecting residents from acquiring a healthcare-associated infection.

The provider had effected audits to ensure oversight of IPC practices in the designated centre. These included a monthly infection control checklist as well as a hygiene audit which was completed in April 2022. These audits identified areas for improvement. It was evident on the day of inspection that several actions identified in the hygiene audit in April had already been addressed while others were in progress. The inspector reviewed the provider’s infection prevention and control policy and found that improvements were required to ensure that information was sufficiently detailed to support staff in their roles. The inspector was informed that this policy was under review at the time of inspection.

Regulation 10: Communication

The inspector saw that residents had access to their preferred communication systems in line with their assessed needs. Staff were knowledgeable regarding residents' preferred modes of communication as outlined in residents' communication and behaviour support plans. Staff were also observed interacting with residents using residents preferred modes of communication such as Lámh.

Judgment: Compliant

Regulation 17: Premises

The designated centre was designed and laid out in a manner to meet the assessed needs of the residents. It was clean, suitably decorated and generally maintained in a good state of repair. However, the flooring in two resident's bedrooms were awaiting replacement as they were damaged. The centre was equipped with technology to support accessibility and there was availability of facilities for recreation and relaxation.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was an adequate supply of nutritious and wholesome food available to residents in the designated centre. Staff had received training in feeding, eating, drinking and swallowing (FEDS) and were available to support those residents with FEDS needs. FEDS care plans were available on file and staff were knowledgeable regarding these. However, there was inconsistency among staff in the procedure to test the thickened level of fluids in line with resident care plans. Additionally, it was not clear how residents were consulted with regarding their meals and therefore how they were offered choices which were consistent with their preferences.

Judgment: Substantially compliant

Regulation 20: Information for residents

A residents guide was available to residents which met the requirements of Regulation 20.

Judgment: Compliant

Regulation 27: Protection against infection

The designated centre was found to be clean and tidy. Staff were aware of their roles and responsibilities and had received training in infection prevention and control (IPC) practices. Staff were seen to be wearing appropriate personal protective equipment (PPE). The provider's infection prevention and control policy required review in order to provide sufficient detail to staff on effective IPC practices. This review was in process at the time of inspection. Amendments were also required to the practices in place in relation to monitoring for symptoms of COVID-19 among residents in line with current public health guidance.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire evacuation procedures were found to be insufficient and required review. In particular, it was found that:

- night-time fire drills were not always reflective of the actual numbers of residents and staff who would typically be in the designated centre at this time
- the procedures and processes for a full-site evacuation by night were not clear and were insufficiently detailed
- the side gates of the designated centre were padlocked and these keys were not readily available in the event of an evacuation being required
- the key to open one of the side fire exit doors was absent on the day of inspection. This had been removed due to risk of absconding for one resident however this had not been risk assessed
- two final exits, the side exits, were found to be key locked.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider was in the process of implementing a system to ensure that assessments of need and care plans were updated regularly. The designated centre was supported by a respite liaison nurse. The respite liaison nurse supported the person in charge to gather information required to update personal plans and had

created a database to ensure that plans would be updated in a timely manner.

On a review of residents' files, the inspector saw that all residents had an assessment of need on file which informed care plans. However, a significant number of assessments of need and care plans required review and updating as these were out of date.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Staff had up-to-date knowledge and skills in responding to behaviour that is challenging in the service. Staff were aware of residents' behaviour support needs and could describe the strategies as detailed in residents' behaviour support plans to assist residents with managing their behaviour. Restrictive practices which were in place in the centre had been logged accordingly, notified to the Chief Inspector and reviewed by the provider's rights' committee.

Judgment: Compliant

Regulation 8: Protection

The registered provider had mechanisms in place to protect residents from abuse. All staff had completed relevant safeguarding training and were found to be knowledgeable in this regard. Incidents or allegations of abuse were investigated and notified accordingly. Safeguarding plans were in place for those residents who required them. Up- to- date intimate care plans were also available on residents' files and provided person-centred information on residents' preferences and choices.

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	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Donabate Respite 2 OSV-0002388

Inspection ID: MON-0028278

Date of inspection: 11/05/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A staff member has been recruited and is commencing on the July roster. Only known relief staff work in Donabate respite 2 to ensure continuity of care.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Contact has been made with the training dept and outstanding in person training for First Aid has been scheduled and will be completed by Sept 22. In person fire training has been requested from SMH fire Safety Officer. Date to be confirmed. Feds training for all staff has been requested from SMH SLT Dept. and is scheduled for July 14th	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose:	

The statement of purpose has been amended to reflect the changes requested.These include registering the DC as adult only and describing the role of the respite Liason Nurse. The amended SOP has been forwarded and is available to view.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The new floors are in in place and all works completed, they were installed on 25th May.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: SLT have been invited to the team meeting on 14/07/2022 to update staff training. . Minutes of meeting will be available for review.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: New organizational IPC guidelines are now in situ and all staff will read and sign of on this. Signing sheet will be available to view on site. Pre checks are completed prior to admission to Respite. All staff will update their IPC training on a 6 monthly basis.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions:	

There is a designated point assigned on site to assemble following a fire drill.
Night time fire drills will be conducted with 2 staff on duty and recorded appropritaley.
New handles with a twist lock will be fitted to the exit doors on the corridor 6th July 2022.
Key code locks will be fitted to the side gates, in the interim the padlocks have been replaced with combination locks so no key is needed.
New site evacuation plan has been completed and agrees with SMH Fire Safety officer.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Donabate Respite 2 no longer using a paper system. All staff have access to the computerized system. All staff are assigned key files to update and subsequently update the database.. Outstanding assessments of need are now up to date.

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/07/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/09/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	20/06/2022

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Substantially Compliant	Yellow	14/07/2022
Regulation 18(3)	The person in charge shall ensure that where residents require assistance with eating or drinking, that there is a sufficient number of trained staff present when meals and refreshments are served to offer assistance in an appropriate manner.	Substantially Compliant	Yellow	14/07/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated	Substantially Compliant	Yellow	20/06/2022

	infections published by the Authority.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Red	20/06/2022
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	Red	20/06/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	20/06/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	20/06/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an	Substantially Compliant	Yellow	20/06/2022

	appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	20/06/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in	Substantially Compliant	Yellow	20/06/2022

	needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is 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.	Substantially Compliant	Yellow	20/06/2022