

# eDeposit Ireland

**Helensburgh, OSV-0001703, 25 May 2023**

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

## Issued by the Chief Inspector

Name of designated centre:	Helensburgh
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	25 May 2023
Centre ID:	OSV-0001703
Fieldwork ID:	MON-0040047

## About the designated centre

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

Helensburgh is a designated centre operated by Sunbeam House Services CLG. It provides a full-time community residential service for up to six adults (male or female) with a disability. The centre comprises of two units both in Co. Wicklow but in different towns. One unit comprises of a two-storey house which consists of six individual bedrooms, office, sleepover room, a sitting room, dining room/kitchen, a number of shared bathrooms and utility room. The second residential unit is a house that provides a single occupancy living arrangements. The house consists of three bedrooms and an accessible bathroom, kitchen and dining room and living room as well as a separate laundry room. It has large front and rear gardens. The centre is managed by a full-time person in charge, a deputy and a team of social care and support care workers. The person in charge divides her role between this centre and two other designated centres.

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

Number of residents on the date of inspection:	6
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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
Thursday 25 May 2023	09:15hrs to 16:15hrs	Jacqueline Joynt	Lead

## What residents told us and what inspectors observed

This was an unannounced risk-based inspection of the centre following up on the previous risk-based inspections of the designated centre. Due to an inappropriate emergency admission to the centre there had been a continuation of peer-to-peer behavioural and alleged safeguarding incidents occurring in the residents' home.

Since the previous inspection the provider applied to vary the conditions of registration for the centre and add an additional residential unit to the centre's footprint. This was to support a resident, with complex needs, move to a more suitable living arrangement. As a result of this action taken by the provider, there had been a significant reduction of peer-to-peer incidents occurring in the centre.

Overall, these actions taken by the provider had resulted in positive outcomes for all residents concerned and had led to a much improved lived experience for residents in their home.

The inspector was provided the opportunity to meet with all six residents. Most residents spoke in detail with the inspector and were able to relay their views about their lived experience. Where residents were unable, or did not want to relay their views, on-site observations, conversations with the person in charge and staff and a review of documentation were used to inform a judgment on residents' experience of living in the centre.

On the day of the inspection, the inspector visited the two premises within the designated centre. The inspector was informed that the resident in the single occupancy house might find it difficult for an unfamiliar person to be in their home with them. To accommodate this, the inspector provided a morning's notice of their visit to the residents home. In addition, a copy of the Health Information and Quality Authority,(HIQA), "nice to meet you" document, to provide information about the inspector and their reason for being there, was sent to the resident in advance of the visit.

In the morning, on arrival at the house where five residents were living, the inspector met with three residents who were in the kitchen. There was a calm, relaxed and homely feel to the environment. Residents were sitting and chatting amongst themselves and to staff. Residents were smiling, appearing content and happy.

One of the residents showed the inspector their room and pointed out some of the improvements to the décor that had taken place since the last inspection. The room had been painted a colour that was of the resident's choosing. They resident said they were really happy with the colour of their room. They told the inspector that there were plans in place to purchase new curtains and a new chair was on the way. The inspector noticed that some improvements were still needed to the room and in

particular, to storage the resident's personal care items.

The resident told the inspector that they were now very happy living in the designated centre. While they had previously said they wanted to leave the house, this was no longer the case as they were now very happy to continue living in the centre. The resident said that everyone was happy since there had been a change to the number of residents living in the centre. They said it was a quieter, more relaxed place.

The inspector spoke with another resident, who had previously told the inspector that they were unhappy with who they were living with and at the time of relaying this information, appeared nervous and uncomfortable. However, on the day of the inspection, when speaking to the inspector about their lived experience in their home, they were smiling, appeared content and relaxed and said they were very happy now.

Later in the day, the inspector met with another resident who also informed the inspector that they were happy living in the house. The resident was due to celebrate a milestone birthday at the weekend and seemed happy about the plans in place for a house birthday party. Some of the residents excitedly told the inspector about the plans in place for the birthday, including the type of cake being organised.

In the afternoon, on arrival at the newly added premises, while the resident showed no signs of upset at the inspector being in their home, the resident chose not to engage with the inspector. The inspector observed the resident, supported by their staff member, preparing their evening meal. The resident appeared content cutting and chopping up the ingredients needed to make the dish. The inspector was informed by staff and the person in charge, that the resident enjoyed preparing and making their own meal each evening.

The inspector carried out a walk-about of the new premises and found that the house was bright, spacious and homely. The resident was provided with their own bedroom and bathroom. The kitchen was large and provided a good space for preparing and cooking food which was in line with the resident likes and preferences. The sitting room was a good size and provided a comfortable space for the resident to relax. There was a garden out the front and back of the house. There was a separate small building at the back of the house which was used as a laundry and storage room.

The resident had been supported, at a pace that met their needs, to transition into this house three weeks previous to the inspection. This was a temporary home for the resident until their full-time one bedroom apartment was available to them in August 2023. There was a transition plan in place for the resident which included two phases, the first being the move to the temporary location and the second their permanent location. It was evident from speaking with the person in charge, staff and a review of documentation that the resident was very much part of, and had been consulted about, the transition to each location.

In summary, the inspector found that there had been significant improvements to the lived experience of all residents living in the designated centre. There had been

a reduction in behavioural and safeguarding incidents occurring in the centre which resulted in positive outcomes for residents. The inspector found that overall, each resident's well-being and welfare was maintained to a good standard and that there was a strong and visible person-centred culture within the designated centre.

Through speaking with residents and staff, through observations and a review of documentation, it was evident that staff and the local management team were striving to ensure that residents lived in a supportive and caring environment.

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

This inspection was carried out to follow up on previous risk focused inspections where there had been continued non-compliance and in particular, where the inappropriate emergency admission of a resident, had not been appropriately addressed and was continuing to impact negatively on the lived experience of residents. On the day of the inspection, the inspector found that the provider had addressed the matter and that residents were now experiencing a positive lived experience in their respective homes.

On the day of the inspection, the inspector found that, for the most part, there were satisfactory governance and management systems in place within the designated centre to monitor the safe delivery of care and support to residents. Care and support provided to the residents was person-centred and the provider and person in charge were endeavouring to promote an inclusive environment where each of the resident's needs and wishes were taken into account. There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a part-time deputy manager. On a day to day basis, the centre was adequately resourced to meet the needs of the residents.

The provider had applied to vary their conditions of registration to include an additional premises to the footprint of the designated centre to ensure the centre met the needs of all residents. While the new premises was a temporary location, the provider had also ensured that the permanent full-time home would be available to the resident in the coming months.

While there remained some residual compatibility issues for residents that lived in the larger home, there had been a significant decrease in the submission of safeguarding notifications to HIQA. Residents were now in receipt of a service that was safe and was meeting their assessed needs. Overall, the inspector found that

the improvements made by the provider had ensured residents safety and well-being and was promoting a positive lived experience for residents living in the designated centre.

The inspector observed that there was a staff culture in place which promoted and protected the rights and dignity of residents through person-centred care and support. Since the last inspection, there had been improvements to staffing levels. Staffing arrangements included enough staff to meet the needs of residents and overall, were in line with the statement of purpose. There was continuity of staffing so that attachments were not disrupted and support and maintenance of relationships were promoted.

There was a decrease in use of external agency staff and systems had been put in place to better support agency staff with the day-to-day running of the house. However, a review of access to computerised systems for agency staff was needed. This was to ensure that the systems in place to record important information, relating to the care and support provided to residents, as well as any adverse incidents, were effective at all times.

The education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. The training needs of staff were regularly monitored and addressed by the person in charge to ensure the delivery of quality, safe and effective services for the residents. The inspector found that for the most part, staff had been provided with the organisation's mandatory training and that the majority of this training was up-to-date. However, a small improvement was needed to the systems in place for monitoring and addressing training needs.

There had been improvements to a number of the governance and management systems in place in the centre since the last inspection and in particular, system to ensure appropriate oversight in the centre. However, the inspector found that a review of the capacity of the person in charge to have oversight over the two designated centres, (three houses), was needed. This was to ensure that the person in charge had sufficient time and support to effectively implement the local governance and management systems in place. In particular, to ensure that required records were kept in accordance with the appropriate schedules and that they were at all times, in place, maintained and updated when required.

There had been improvements in compliance with submitting required notifications of incidents, since the last inspection. Overall, the inspector found that incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements. The person in charge ensured that incidents were notified in the required format and with the specified time-frames to the Chief Inspector.

## Regulation 15: Staffing

Since the last inspection, two new staff had taken up positions and a deputy manager had been employed on a part-time basis. In addition, a behavioural specialist had been employed in the centre, who also worked as a social care worker.

There was a reduction in the number of agency staff employed and where agency were employed, the person in charge was endeavouring to use the same five to six staff members.

There was a handover folder in place to specifically support external agency staff be knowledgeable and aware of each resident's assessed needs and their associated care plans. The handover folder also included matters relating to the day-to-day running of the centre, local and senior management contacts including out of hours on-call details.

In addition, agency staff had been provided access and shown how to use the computerised system in place where the most up-to-date information relating to the residents care and support was recorded and reviewed. However, the access to the computerised system was time-limited to a two week basis. This meant that at times, access was not always readily available to staff and where this was the case, they had to revert to paper format or rely on other staff to fill out their reports. Overall, a review of the latter system was needed to ensure it was effective at all times.

Overall, staff who spoke with the inspector demonstrated good understanding of the residents' needs and were knowledgeable of policies and procedures which related to the general welfare and protection of residents living in this centre. On speaking with a number of staff, the inspector was informed of the recent positive outcomes for residents since one of the residents moved to a house that better met their needs. Staff relayed how the living environment was much calmer and relaxed and how residents seemed much happier. Some staff told the inspector that they had worked in the newly added house, and that the resident living there seemed content in their new environment.

Judgment: Compliant

## Regulation 16: Training and staff development

There was a training schedule in place for all staff working in the centre. The inspector found that, for the most part, staff had been provided with the organisation's mandatory training and that the majority of this training was up-to-date.

However, while the training matrix in the local auditing folder, which monitored staff training, demonstrated a number of staff deficits in staff refresher training, on review of the computerised system, the inspector found that majority of staff

refresher training was up-to-date. (This has been addressed further under Regulation 21).

Judgment: Compliant

### Regulation 21: Records

The inspector found that improvements were needed to systems in place to ensure that all required records were in place, maintained, updated as required and were available for inspection at all times.

For example, in one of the houses within the designated centre, the training matrix, monthly household audits, resident's infection prevention and control care plans as well as associated risk assessments and self isolation plans required review and updating.

In the other premises, where a resident had recently moved to, a number of records had not yet been put in place. For example, fire safety records relating to safety equipment checks, fire safety statement and evacuation plans and drills. In addition, household audits and a register of risks specific to the centre and resident living in the centre, were also not in place.

Subsequent to the inspection, the person in charge submitted a copy of all of the above documentation which they advised is now in location.

Judgment: Substantially compliant

### Regulation 23: Governance and management

Since the last inspection, the provider had put measures in place to ensure the safety of residents living in the designated centre. As a result there had been a significant decrease in behavioural and alleged peer to peer safeguarding incidents occurring in the house and overall, resulted in positive outcomes for all residents.

The provider had sourced temporary alternative living accommodation for a resident that better met their needs and sourced and registered a property that would become the residents full-time home in August 2023. This meant that the provider was now providing a service that was currently meeting the assessed needs of all residents.

The person in charge divided their role between two centres, one of which had a new premises added to it. The person in charge was supported by a part-time, (two days per week), deputy manager, to assist them with the local operational oversight, administration and governance and management of the centre. However,

a review of the capacity of the person in charge to manage an additional unit added to the designated centre was needed.

Overall, a review of the records of information and documents in relation to specified Schedules was needed and in particular, regarding the new premises added to the centre. In particular for Schedule 3 and 4.

A review of the maintenance systems in place was required to ensure that where repairs related to a safety risk, that these were addressed in a timely manner (this has been addressed further in regulation 28).

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

The person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. The person in charge had also ensured that quarterly and six-monthly notifications were being submitted as set out in the regulations.

Judgment: Compliant

### Quality and safety

The inspector found that the provider and person in charge were endeavouring to ensure that residents well-being and welfare was maintained to a good standard. There was a strong and visible person-centred culture within the centre. The person in charge and staff were aware of residents' needs and knowledgeable in the care practices to meet those needs. Care and support provided to residents was of good quality. Since the last inspection there had been a lot of improvements in the centre which resulted in positive outcomes for residents. In particular, where a resident was supported to move to a house that better met their needs, this had overall, had a positive impact on the lived experience for all residents.

There had been a significant decrease in peer-to-peer behavioural and safeguarding incidents occurring in the centre. Residents who spoke with the inspector advised that they no longer felt unsafe or anxious in their home. The reduction in these incidents meant that residents were happier living in their home and overall, were enjoying a good quality of life in their home. While some residual compatibility issues remained, reviews of the layout of the kitchen and dining room were underway, which had the potential to reduce or mitigate peer incompatibility related incidents occurring going forward.

The inspector visited both houses on the day of the inspection. Overall, all residents were living in premises that meet their assessed needs. For the most part, the design and layout of the premises ensured that each resident could enjoy living in a safe, comfortable and homely environment. This enabled the promotion of independence, recreation and leisure and enabled a good quality of life for the residents living in the centre.

There were number of upkeep and repairs works needed in one house which was potentially impacting on the infection prevention and control measures in place in the house. This was identified on the last inspection and some improvements had been made. In addition, the provider had organised an external contractor to complete an infection prevention and control audit of one of the houses in the centre, which also had identified works to be completed. The person in charge, was currently progressing the action plan.

On the day of the inspection, a fire safety improvements were identified. The person in charge and senior management had identified the risk in March 2023 and had notified it to the appropriate department within the organisation. However, the issue was only resolved on the day of the inspection. Furthermore, while assurances were submitted regarding the fire safety systems in place in the new location, overall the inspector found that a review of the fire containment measures in the house was required, to ensure they provided optimum safety at all times.

## Regulation 26: Risk management procedures

The risks that were identified on the last inspection were either reduced or near the end stages of being mitigated . For example, a new call bell system had been installed in residents' bedrooms so that staff could come to their aid if required. The person in charge had sourced an extension to the call bell press button to ensure better accessibility for all residents using the system.

The risk of a resident not self-isolating in the house had been mitigated with the addition of a newly added premises.

There was a risk register in place for the designated centre which included centre specific risks as well as individual risk, however, it was specific to one of the premises only. There had been no site-specific risk assessments completed for the new location or of potential risks that may impact on the resident living in the centre. Matters relating to the site-specific risk register have been addressed in regulation 21.

Judgment: Compliant

## Regulation 27: Protection against infection

An infection prevention and control (IPC) audit, to supported the provider met the requirements of Regulation 27 and the *National Standards for Infection Prevention and Control in community services (2018)*, had been completed in one of the houses within the designated centre in March 2023.

The audit was comprehensive in nature and identified many of the issues found on the last inspection including some of the issued identified on this inspection. The audit identified a number of actions to be completed which the person in charge was currently addressing. Some of the actions included upkeep and repair to areas of the house and in particular, painting of house walls and work to the facilities in two of the bathrooms. The audit also identified that updates were required to some of infection, prevention and control records in place such as residents care plans, risk assessments and their individual self-isolation plans.

Some updates were required to ensure that the most up-to-date Health Protection Surveillance centre (HPSC) guidance was made available to staff and that the outbreak management plan was updated in line with the change in configuration of the centre. (This has been addressed in regulation 21).

Judgment: Compliant

## Regulation 28: Fire precautions

On reviewing the maintenance requests and schedule for the designated centre, the inspector saw that a request to fix a fire door (a resident's bedroom door) had been submitted by the person in charge in March 2023.

On the day of the inspection, the inspector observed that the bedroom door did not close when the fire alarm sounded. The door was generally kept open to meet the mobility needs of the resident who slept in the room. However, on the day of the inspection, senior management organised for the door to be fixed. On leaving the centre, the inspector observed the fire door to be working effectively when the fire alarm sounded. However, this demonstrated there was not timely action taken by the provider when such matters were self-identified, this required improvement.

In the newly added premises to the designated centre, improvements were needed to ensure that there was appropriate fire safety records in the house. For example, there was no site-specific safety statement for the premises, there was no evacuation plan or escape route plan in place, there were no monthly, weekly or daily fire checks in place, there had been no fire drill completed with the resident, the resident's personal evacuation plan had not been updated in line with the new location and none of the doors in the house were fire doors. Subsequent to the inspection, the person in charge submitted, the required documentation for the newly added premises.

In addition, while a number of fire safety assurances had been submitted when the

new house was being added to the centre, on the day of the inspection, the inspector found that the arrangements in place for fire containment required review. This was to ensure that the containment arrangements were adequate and ensured appropriate and effective fire safety precautions and measures in the centre.

Judgment: Not compliant

## Regulation 8: Protection

Alternative living arrangements had been sourced for a resident who had been admitted into the designated centre on an emergency basis. Since the last inspection, an application to vary had been completed to add a new premises to the centre. Three weeks previous to the inspection, a resident had been supported to moved into a home that better met their assessed needs. Overall, this had resulted in positive outcomes for the resident. In addition, this also had a positive impact on the lived experience of residents in the other premises of the designated centre. There had been a significant decrease in behavioural and alleged safeguarding incidents occurring in the centre.

Previous to the emergency admission, it had been identified that there were compatibility issues in the centre relating to the layout of the environment. The provider had in the past changed the layout and function of some rooms in an effort to alleviate the compatibility issues. However, the changes had not been effective.

On the day of the inspection, the person in charge advised of a plan to change the layout of the kitchen and dining area (where most of the residents gathered and where most of the incidents relating to compatibility issues occurred). The provider and person in charge were in the process of sourcing a table that would better meet the accessibility needs of two residents. This table would change the layout of the dining area and create more space and had the potential to reduce, and possibly mitigate, peer to peer behavioural incidents in that communal area. However, the process was at an early stage and there was no completion time frame in place.

Some of the safeguarding plans that had been in place for five residents were no longer required however, where safeguarding plans were needed, (for four residents), they had not been included in their personal plans.

Judgment: Substantially 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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
<b>Quality and safety</b>	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Substantially compliant

# Compliance Plan for Helensburgh OSV-0001703

Inspection ID: MON-0040047

Date of inspection: 25/05/2023

## 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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Training matrix updated and reviewed regularly – last review 13/06/2023 Monthly Household audits in place Risk Register for specific Designated Centre in place resident's infection prevention and control care plans as well as associated risk assessments and self isolation plans will be reviewed and updated by 30/07/2023	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A review of the capacity of the person in charge to manage an additional designated center has taken place. PIC for the new designated center will be appointed by 01/09/2023. <ul style="list-style-type: none"> <li>• The risk Register is completed, and control measures identified with reducing the risk due to no fire doors.</li> <li>• Fire signs with exit routes in place</li> <li>• SHS fire prevention &amp; emergency evacuation best practice plan documentation</li> <li>• fire and evacuation plan and emergency evacuation protocol documentation</li> <li>• PEEP (also in client folder and on display for residents' needs)</li> <li>• emergency numbers</li> <li>• daily fire checks</li> <li>• monthly inspection checks- Lightening, extinguishers, fire signs, first aid box, CO2 alarm, client equipment.</li> <li>• fire drill completed monthly pending residents' engagement, however should resident not wish to engage staff will continue to have fire evacuation discussions with the resident.</li> <li>• weekly testing of fire alarm and CO2</li> <li>• floor plans and floor plan with escape route marked and on display in communal area</li> </ul> PPIM highlighting to the Provider that any future use of the temporary designated premises for any other residents will require upgrade works to fire doors.	

Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:  In the newly added premises the following are now in place:</p> <ul style="list-style-type: none"> <li>• The risk Register is completed, and control measures identified with reducing the risk due to no fire doors.</li> <li>• Fire signs with exit routes in place</li> <li>• SHS fire prevention &amp; emergency evacuation best practice plan documentation i</li> <li>• fire and evacuation plan and emergency evacuation protocol documentation</li> <li>• PEEP (also in client folder and on display for residents' needs) updated 26/05/2023</li> <li>• emergency numbers</li> <li>• Monthly, weekly, and daily fire checks</li> <li>• monthly inspection checks- Lightening, extinguishers, fire signs, first aid box, CO2 alarm, client equipment.</li> <li>• fire drill completed monthly pending residents' engagement, however, should resident not wish to engage staff will continue to have fire evacuation discussions with the resident.</li> <li>• weekly testing of fire alarm and CO2</li> <li>• floor plans and floor plan with escape route marked and on display in communal area.</li> <li>• Safety Statement in place June 2023</li> </ul> <p>PPIM has highlighted to the Provider that any future use of the temporary designated premises to facilitate upgrade works will require additional risk mitigation measures in relation to fire.</p> <p>As a result, the Provider's health and safety officer has completed a risk mitigation report on 18.7.23 in relation to fire. This outlines various measures to be implemented by the provider to facilitate any future use of the designated center. This report has been attached with the compliance plan.</p> <p>The report includes some of the following actions;  Replacing the existing double doors from the living room to the entrance hall with an FD60 fire door set and replacing the existing door from the kitchen/diner to the entrance hall with an FD60 door set.  Bedrooms 1, 2 and 3 will be fitted with 30 minute fire doors.  Ensure that clients occupying the residence are fully ambulant.  Only waking night time staff shall be used.  Eliminate the use of extension leads in the house, especially the living room. Install additional electrical sockets, if required.  Relocate the 6ltr foam extinguisher from the kitchen to the entrance hall adjacent to the 2KgCo2 extinguisher (both extinguishers will then be outside the risk area and available for use in an emergency).  Complete monthly fire evacuation drills to ensure occupants can leave the building in an emergency situation.</p>	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:  To further meet the accessibility needs of two residents, there is a plan in place to change the layout and thusly create more space which has the potential to mitigate</p>	

negative peer to peer interactions in the communal area of the kitchen and dining room. Joinery contacted to constructed bespoke table, awaiting date of completion. Residents now use the other areas of the house more frequently which is hoped to mitigate, peer to peer behavioural incidents. Residents take part in activities of choice outside of the residence to decrease possible incidents due to, to much conegregation in this area. Safeguarding plans to be completed by 30.07.2023 and will be inserted into personal plans.

## 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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/07/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/07/2023
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents'	Substantially Compliant	Yellow	15/06/2023

	needs, consistent and effectively monitored.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/11/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/07/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	30/07/2023