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:	Hazel Grove
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	18 November 2020
Centre ID:	OSV-0004638
Fieldwork ID:	MON-0030880

About the designated centre

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

Hazel Grove comprises of two properties located within a relatively short drive of each other. Both properties are located in populated areas in walking distance of services such as shops, restaurants and public transport links. The centre provides a residential service for a maximum of seven residents assessed as requiring a broad range of staff support from supervision to full support with all activities of daily living. One property is a single-storey detached house where an individualised service for one resident is provided. The other property comprises of four apartments that accommodate up-to six residents on a single occupancy or shared basis; the maximum occupancy of each apartment is two residents. The apartments offer semi-independent living arrangements for residents. In each location there are two staff available to offer care and support during day-time hours and one staff during night-time hours. The model of care is social and the staff team is comprised of social care and support workers with day to day management delegated to the person in charge supported by a lead social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 18 November 2020	09:45hrs to 17:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

While cognisant of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19 the inspector sought to maximise, in consultation with the centre, the opportunities to meet with all residents if they wished, so that their feedback informed the inspection findings. The residents welcomed the opportunity to meet with the inspector and five residents were met without the need to enter their individual apartments. These residents provided very clear, informed and insightful feedback of what life was like for them now in the context of COVID-19 and the current Level 5 restrictions. Residents spoke of the dramatic changes that this had brought for them such as losing the opportunity to enjoy work, activities such as swimming, restricted access to peers and family and simply not being able to access as they choose the wider local community. Residents were very informed and very aware of the risk posed to them by COVID-19, they each readily practiced physical distancing and some residents were quite comfortable using a face mask while speaking with the inspector. Residents were very open in speaking about the difficulties and challenges that all of this raised for them, but what was also very evident was their acceptance, resilience and hope. Residents said that they felt safe in the centre and while they missed many activities they were also cautious of for example, going to crowded places like shops. Residents described how they made sure that they had a good daily routine, kept themselves busy, went for walks to get some exercise and went into town with staff in the transport provided. Residents described how they kept in contact with family and friends by phone, messaging or face-time. Residents were hopeful that a vaccine would be available soon and said they would avail of it. Residents told the inspector that they liked the independence they had in their apartments and that it suited their needs and choices. Residents confirmed that they had access to and support as needed from staff and described how they would contact staff when staff were not based in their apartment. Where staff were based in the same apartment residents said that they were quite happy with this arrangement. Residents told the inspector that they could talk to staff, the person in charge and members of the multi-disciplinary team (MDT) when they needed to. Residents said that they received the emotional support that they needed when they were a little challenged by life and its events. Residents told the inspector that all was good in the apartments, that there was nothing bothering them and nothing they would like to see changed. Where residents needs were higher and they were not in a position to provide such clear feedback the inspector noted that they were clearly able to communicate to staff what it was they wished to do. The care and support they were provided with was in line with their plan of support and as advised by the multi-disciplinary team (MDT). Over the years, residents had clearly formed relationships with staff and the importance of these relationships was reflected in their home and in their plan. Staff were attentive, knowledgeable and vigilant in their monitoring of the effectiveness and safety of the care and support provided.

Capacity and capability

There was some scope for improvement and there was some uncertainty over the allocation of adequate resources, but overall this was a well managed and overseen service that was focussed on the provision of a safe, appropriate service to residents.

The management structure was clear as were individual roles, responsibilities, lines of authority and accountability. The person in charge was satisfied that she could effectively perform her role given the commitment of the staff team, the support from the lead social care workers and ready access and support from her line manager. The person in charge described how oversight was maintained through for example staff meetings, staff supervisions, case-conferences, the review of incidents and accidents and on-going consultation with residents. The provider was also completing the annual review and the unannounced reviews that are stipulated in the regulations. The inspector reviewed the report and findings of the most recent unannounced review completed in June 2020, actions required for improvement had issued from this review. Based on these Health Information and Quality Authority (HIQA) inspection much but not all of the action plan had been progressed, for example staffing levels were increased and deficits in staff training were largely clarified. However, further work was needed, for example in risk management systems. The provider was requested to review, based on verbal feedback of the inspection findings a specific risk assessment seen by the inspector to ensure that the risk was adequately controlled. This was addressed by the provider in a timely fashion and the required assurance was in the revised risk assessment. In addition however, while feedback was sought from residents and representatives as part of these internal reviews, the response to that feedback was not timely. Overall the feedback received was positive but feedback received by the provider in March 2020 as to the perceived individual appropriateness of the service was not addressed until November 2020 and while there now was a plan for further follow-up, the matter was not fully resolved.

Overall the inspector found that staffing levels, arrangements and skill-mix were currently suited to the number of and the assessed needs of the residents. Staffing levels had in recent months been increased in the individualised service in response to increasing resident needs. This increase meant that the resident could remain in their own home and receive, based on these inspection findings a good standard of individualised safe and appropriate care from staff known to them. There was evidence of positive outcomes for the resident as a result of the increased staffing levels including a reduction in behaviour that challenged and reduced reliance on chemical intervention. While the provider said that this additional staffing was not funded, the provider also confirmed that the provider would maintain this staffing while pursuing the requested funding.

The person in charge confirmed that all staff were regularly employed and this provided consistency and continuity for residents and staff; this consistency was

evident in the staff rota. The staff skill-mix did not include nursing staff. Residents needs were changing and increasing and the inspector saw from records such as healthcare records that nursing advice and support was needed at times, and was facilitated by resources such as public health, the General Practitioner (GP) practice and nursing colleagues from another nearby centre. The inspector found that the care and support provided by staff in the centre was of a good standard but would have been further assured by access to and support from a dedicated nursing resource, that would for example review and advise on care plans and assist in the completion of clinical assessment tools. At verbal feedback of the inspection findings the provider confirmed that there were plans to shortly pilot and trial such a resource.

The inspector reviewed staff training records and was satisfied that the gaps in the verification of training found at the time of the internal provider review had been largely addressed. For example there was documentary evidence that all staff had completed training in response to COVID-19 including hand-hygiene, breaking the chain of infection and correctly using personal protective equipment. The training programme was responsive to the changing needs of the residents and staff spoke of the benefit to them and their practice of having completed dementia training with an accredited training provider. Where face to face training was prohibited or delayed by COVID-19 staff completed interim on-line training, for example in safeguarding and responding to behaviour of concern and this practice was risk-assessed. Staff knowledge and practice was further enhanced by input from the MDT for example in the provision of modified diets, falls prevention and safe movement techniques in resident care. However, the inspector did note in the context of the assessed risks in this centre that some staff had yet to complete first-aid training while other staff were overdue refresher training. With due regard for changing needs and recent diagnoses, consideration should also be given to providing additional targeted dementia specific training to further support staff to develop their knowledge and skills.

Regulation 14: Persons in charge

The person in charge worked full-time and had the skills, qualifications and experience necessary to manage the designated centre. The person in charge was satisfied that they had the structures and the support needed to effectively exercise their role and responsibilities, and to escalate within the governance structure as necessary, matters that arose. The person in charge ensured that she maintained a regular presence in both units and was accessible to staff and residents. The person in charge was open to the process of and the learning to be gained from inspection and inspection findings.

Judgment: Compliant

Regulation 15: Staffing

Based on the evidence available the inspector found staffing levels, arrangements and skill-mix suited to the number of and the current assessed needs of the residents. Staffing levels had in recent months been increased in response to increasing resident needs and risks. The provider assured the inspector that these staffing levels though unfunded would be maintained.

Judgment: Compliant

Regulation 16: Training and staff development

In the context of assessed risks in this designated centre some staff had yet to complete first-aid training while other staff were overdue refresher training. With due regard for changing needs and recent diagnoses, consideration should be given to additional targeted, dementia specific training to further support staff in developing their knowledge and skills.

Judgment: Substantially compliant

Regulation 21: Records

Any of the records requested by the inspector, and used to inform and validate these inspection findings were readily available and were well maintained.

Judgment: Compliant

Regulation 23: Governance and management

The inspector reviewed the report and findings of the most recent unannounced internal review completed in June 2020, actions required for improvement had issued. Much but not all of the action plan had been progressed and further work was needed in, for example risk management systems. In addition while feedback was sought from residents and representatives as part of these internal reviews the response to that feedback was not timely. Overall the feedback received was positive but feedback received by the provider in March 2020 as to the perceived individual appropriateness of the service was not addressed until November 2020

and while there was a plan for further follow-up, the matter was not fully resolved.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector saw that the statement of purpose was available in the designated centre, that it was kept under review and updated as needed, for example following the increase in staffing levels.

Judgment: Compliant

Quality and safety

Improvement was needed in areas such as risk management, fire safety and the review of restrictive practices. Fundamentally however, the overall evidence was of a service where residents received individualised, support and care that was suited to their needs and choices, that promoted their well-being, safety and quality of life.

The inspector reviewed one personal plan in detail and found that it was of a good standard. The plan was informed by staff knowledge of the resident and regular input from the relevant members of the MDT. The residents' needs, the plan and its effectiveness, were kept under review and this review included regular MDT review that reflected the level of MDT input the resident received. It was evident from the plan that staff followed through on any recommendations made at these reviews for example in relation to speech and language therapy (SLT). The resident, their safety and well-being was the focus of the plan and the support and care described in the plan was readily observed in practice, for example in relation to falls-prevention. The plan included the plan for pursuing personal goals and objectives. This aspect of the plan demonstrated the knowledge that staff had of the resident and staff commitment to continue, despite declining function, meaningful and purposeful engagement that preserved functioning and access to what was important and of value to the resident when they had enjoyed better health. For example staff ensured that the resident continued to have access to and be visible in their local community and to visit places of personal interest and importance to them such as their place of origin and the church.

The personal plan also included the plan for maintaining resident health and well-being. Staff maintained detailed records of any healthcare related matters including consultation with and review by a range of clinicians such as the General Practitioner (GP), psychiatry, occupational therapy, SLT and physiotherapy. What was evident from these records was staff knowledge and understanding that ensured effective

and responsive monitoring of resident well-being and of the care provided. For example staff were aware of and monitored the impact of medicines on resident mobility, staff understood and monitored for any signs of inadequate fluid intake, staff followed-up on findings for example where bloods were taken and sent for analysis. The equipment needed for resident well-being, comfort and safety and staff safety was provided, for example a mattress to support skin integrity, equipment to support safe movement and transfers and interventions to reduce the risk of falls and injury as a result of a fall.

There were times when residents were challenged to cope with events and behaviour of risk also presented as part of the overall diagnosis or as a means of communication. Residents themselves spoke of the support they received from staff and from the relevant members of the MDT such as psychology and psychiatry. Where appropriate, the behaviour, its triggers, its meaning and responsive strategies were set out in a positive behaviour support plan that was reviewed as part of the overall plan of support. Integrated MDT working was evident in the cross referencing of the plan by for example behaviour support and SLT. Overall there was good awareness of therapeutic and restrictive responses, for example staff were very aware of the positive impact of increased staffing on behaviour related incidents and the reduced requirement for chemical interventions. The use of such medicines was monitored by the person in charge and these records reflected the decreased usage.

However, in the context of residents assessed needs and wishes, there were associated risks and some restrictive practices to manage and reduce those risks. Despite the awareness mentioned above and systems of review and oversight the inspector found that the review of the use of restrictive interventions needed to be more timely and more responsive to change. This was needed to ensure that the interventions were the least restrictive procedure, were proportionate to the level of risk that presented, used only as a last resort and withdrawn when less restrictive interventions were effective. For example in the apartments residents wanted and enjoyed some independence and reported this themselves to the inspector. Interventions used in support of this included alarms to alert staff at night and at prescribed intervals by day if an apartment door was opened. Based on the evidence available to the inspector these were reasonable, precautionary measures that did not impact on resident choice, privacy and autonomy. However, where resident needs were higher there were other interventions that did impact on residents such as the use of a monitor where residents would have had a reasonable expectation of privacy. There was a rationale for the use of the monitor (falls prevention) but the increased staffing levels referred to in the first section of this report meant that the rationale for its use was not now as robust and adequate staffing provided for the supervision necessary. However, while staff reported reduced use of the visual monitor it was still in place.

Some improvement was needed in the management and ongoing review of risk. There was an absence of assurance in some risk records seen though the practice reported and observed was safe and evidently based on the assessment and management of risks. This assurance was important as residual risk at times informed the use of a restrictive intervention such as the monitor mentioned above,

and also informed responsible risk taking by residents such as time spent alone in their apartments. The inspector reviewed a purposeful sample of risk assessments such as a risk of choking, a risk for falls and time spent alone and found that there was some duplication of risk assessments, disparity in residual risk ratings where the was a common risk and a lack of assurance that risks were adequately controlled. For example the risk for slips and trips and for falls were separated and this segregation was reflected in the inconsistency of residual risk ratings, and in the reported number of incidents and events that informed the level of risk and the adequacy of existing controls. Staff also used a range of assessment tools to assess the risk of falls and while solid lines of enquiry were used there was no overall scoring framework to guide staff when assessing the risk that presented.
Risk assessments for periods of time that residents spent alone needed to focus on the individual skills and abilities that made this safe such as ability to use the phone, ready response to the fire alarm, as well as the controls that supported safety, such as the provision of personal alarms. However, the practice observed and the assurance submitted by the provider following this inspection provided evidence that these were potentially documentary deficits and identified risks were managed. For example staff spoken with were clear on the recommendations made by the SLT to ensure that residents could eat and drink safely, the inspector saw interventions designed to reduce the risk of injury from falls such as low-low beds, equipment to aid effective evacuation and safe staff practice when assisting residents to move position or to transfer.

There was evidence of controls designed to prevent the accidental introduction and onward transmission of COVID-19. For example inspector well-being was ascertained prior to entering the designated centre and prior to meeting with residents. There were established procedures for monitoring resident and staff for symptoms that raised an index of suspicion for COVID-19. It was evident that residents were informed and educated of both the risk that presented and the measures that they could and did take to reduce that risk including reducing their contacts, physical distancing, hand hygiene and the wearing of a face covering. The inspector saw that hand-hygiene, cleaning and sanitizing products were readily and easily accessible and staff were vigilant in cleaning contact points and surfaces. Staff were seen to use their face mask in line with national guidance, the person in charge described how she visually spot-checked adherence to infection prevention and control measures when she called to each house. The person in charge had also assessed practice in the centre used the HIQA self-assessment tool. The risk register had been updated to reflect the risk posed by COVID-19 and each resident had a contingency plan in the event of suspected or confirmed COVID-19. Some minor review was needed to one such plan and this was explained during the inspection process. The person in charge described how the assessment of risk was continuously evolving and was used to support safe decision making by residents, particularly in times of lower national restrictions when shops and services were open and accessible, for example visiting the barber. The inspector was advised that recent HIQA inspection findings in relation to overarching policy and procedure were under review at the appropriate level of the organisation.

Overall there was evidence of effective fire safety procedures though action was needed to further improve these. The inspector reviewed the fire safety register for

both locations and saw that the fire detection and alarm systems, the emergency lighting and fire-fighting equipment were inspected and tested at the required intervals. Staff also completed regular in-house monitoring of these systems and staff and residents participated in regular simulated evacuation drills. Where challenges to evacuation had arisen, responsive action was taken such as acquiring devices to support evacuation and updating the personal emergency evacuation plan (PEEP) accordingly. Staff participation in these drills was monitored to ensure that all staff participated and implemented the procedure set out in the PEEP. One PEEP and associated risk assessment did require review however as it was unclear on reading the PEEP what the actual risk was and what action was required of staff in the event of fire. Staff spoken with were clear on the risk and the action to be taken. One designated exit in the house was stepped and not ramped and was therefore not suited to the needs or the PEEP of the resident in the event that the exit was required as an evacuation route. Devices designed to close fire-resistant doors were fitted in the house but were not fitted in any of the four apartments.

Regulation 10: Communication

Most residents were effective verbal communicators and gave a good account of their life in the centre. Where additional communication support was needed this was provided and was informed by input from the MDT and by training completed by staff, for example in the area of dementia support. The inspector saw evidence of this in the use of visuals, photographs and sensory programmes. In response to changing needs and change brought about by COVID-19, staff and residents reported increased use of technology to maintain contact with family, peers and the wider world in general. Technology was provided and used, for example personal tablets and devices to alert residents with a sensory impairment in the event of fire.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed a purposeful sample of risk assessments such as a risk of choking, a risk for falls and time spent alone and found that there was some duplication of risk assessments, disparity in residual risk ratings where the was a common risk, and a lack of assurance that risks were adequately controlled. For example the risk for slips and trips and for falls were separated and this segregation was reflected in the inconsistency of residual risk ratings and in the reported number of incidents and events that informed the level of risk and the adequacy of existing controls. Staff used a range of assessment tools to assess the risk of falls and while solid lines of enquiry were used there was no scoring framework to guide staff when

assessing the risk that presented. Risk assessments for periods of time that residents spent alone needed to focus on the individual skills and abilities that made this safe such as ability to use the phone, ready response to the fire alarm as well as the controls that supported safety, such as the provision of personal alarms

Judgment: Substantially compliant

Regulation 27: Protection against infection

There was evidence of controls based on national guidance to prevent the accidental introduction and onward transmission of COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

One PEEP and associated risk assessment required review as it was unclear on reading the PEEP what the actual risk was and what action was required of staff in the event of fire. One designated exit in the house was stepped and not ramped and was therefore not suited to the needs or the PEEP of the resident in the event that it was required as an evacuation route. Devices designed to close fire-resistant doors were fitted in the house but were not fitted in any of the four apartments.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plan reviewed by the inspector clearly described the assessed needs of the resident and the care and support to be provided for the residents comfort, safety, well-being and development. The effectiveness of the plan was the subject of regular review including review by the MDT.

Judgment: Compliant

Regulation 6: Health care

The personal plan included the care to be provided in response to any identified healthcare needs so that residents enjoyed the best possible health. Residents had

access to the clinicians, services and equipment that were needed for their well-being, comfort and safety. Staff monitored and assessed resident well-being in an informed and knowledgeable manner and took responsive action when concerns arose for resident health.

Judgment: Compliant

Regulation 7: Positive behavioural support

While there was good awareness and systems of review and oversight the inspector found that the review of the use of restrictive interventions needed to be more timely and more responsive to change. This was needed to ensure that the interventions were the least restrictive procedure, were proportionate to the level of risk that presented, used only as a last resort and withdrawn as soon as less restrictive but effective interventions were put in place.

Judgment: Substantially compliant

Regulation 8: Protection

There were no reported safeguarding concerns. Staff had completed safeguarding training, residents told the inspector that they were safe in the centre. The contact details for the designated officer were prominently displayed. The person in charge ensured that they were accessible to staff and residents and described how many residents could and did call the person in charge directly.

Judgment: Compliant

Regulation 9: Residents' rights

These inspection findings reflected a service where the individuality and rights of residents were respected and promoted. For example residents reported having the support that they needed from staff while enjoying independence and privacy in their apartments. Residents had a good understanding of their needs and the support and care that they needed while confirming that they had good control over their daily routine and choices. The support provided was person centred and individualised and staff were seen to be good advocates for services for residents such as access to clinicians and services. While some improvement was needed in risk management systems the person in charge clearly described the role of risk management in promoting residents rights and including the right to safe,

responsible risk-taking. The provider operated an advocacy forum that was co-ordinated by the person in charge who spoke of how technology had been used to ensure ongoing communication and access to advocacy during the COVID-19 pandemic.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Hazel Grove OSV-0004638

Inspection ID: MON-0030880

Date of inspection: 18/11/2020

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The registered provider shall ensure that (16: a) staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. This will be ensured by: • Staff outstanding for Basic First Aid training (both new staff requiring initial training, and staff who require refresher training) have been booked on training; and will have completed this training by 14/12/2020. • PIC and training dept. have identified suitable further dementia specific training for staff to complete to enhance their skills and knowledge to support the resident. This training will be facilitated in early 2021 Planned Completion date: [30th April 2021].	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider shall ensure that (23:c) management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. This will be ensured by completing the following actions: • The PIC will ensure further development regarding the perceived individual	

appropriateness of the service and the housing placement for one identified resident.
• The PIC has contacted the National Independent Advocate 11th November 2020 to request that an independant evaluation of the current housing placement is assessed in line with the Residents wishes and report if change in living circumstance is warranted. This will evaluate if further steps are required.
• Residents' IP will be further developed in line with the resident's wishes and aspirations in terms of their future living arrangements.
[30th November 2021]

In addition to the above, the PIC will:
• ensure that all actions arising from resident's/ family representatives' feedback as part of the annual review of the designated centre will be completed within appropriate time-frames going forward.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider shall ensure that (26(2) there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies, by ensuring that the following actions are completed:

• All identified risks will be risk assessed as per procedure. The PIC will ensure that where risks have been identified; proportional control measures will be put in place and appropriately documented in the relevant risk assessment.
• The PIC will review and update current risk assessments within the centre, to ensure all control measures have been outlined in each respective risk assessment and that each risk assessment is specific to the resident, and their individual skills and abilities which further reduce the relevant risk.
• The service areas' risk registers will be reviewed in full; to ensure there is no duplication of risk assessments.
• Risk assessments will be reviewed following adverse events; including incidents and accidents (e.g. falls), to ensure there is a live process of reviewing incidents and evaluating the response to support learning and identify further controls required. As part of this process, where relevant, relevant protocols, Behavior Support Plans, Health Care Plans/ Falls Management Care Plans and Individual Plans will in turn be reviewed.
• The PIC will review risk ratings to ensure they are reflective of the actual risk following implementation of controls.
• Feedback has been forward to the NLT on the National Falls Management Policy; to request review of the policy to include a specific scoring framework to guide staff on assessing the risk.

[31st December 2020]

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Regulation 28(1): The registered provider shall ensure that effective fire safety management systems are in place. This will be ensured by:

• PIC has ensured that the identified PEEP highlighted in the inspection was reviewed to clarify the actual risk and all actions required of staff in the event of fire. In addition, the PEEP now outlines the individual relevant skills of the resident. [Completed]
• Required structural works on one of the designated exits in one house (installation of ramp), has commenced, as of 9th December 2020. [Planned completion date: 31/12/2020]
• The PIC has identified the number of doors which require self-closure devices to be installed; and has arranged for the installation of said devices. [Planned completion date: 31/03/2021]
• Risk Assessment updated to identify additional controls required/taken as per updated fire safety for community dwellings guidelines. [Completed]

Completion Date: 31/03/2021

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Regulation 7 (3): The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the planning process; this will be ensured by:

• Following the inspection, the PIC scheduled immediate consultation with staff team in relation to Restrictive Interventions in use, with a view to review and reduce the interventions in place; taking into consideration the reduced risk as a result of implementation of 2:1 staffing. [Complete].
• Meeting with Clinical Principal Psychologist arranged to review and discontinue Restrictive Intervention following agreement of staff team; proposed to only re-introduce use of audio monitor in event of resident becoming unwell/ ill. [Complete]

[Complete]

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 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	30/04/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and	Substantially Compliant	Yellow	30/11/2021

	put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/12/2020
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Substantially Compliant	Yellow	31/03/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	09/12/2020