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:	The Ash
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	18 February 2020
Centre ID:	OSV-0004759
Fieldwork ID:	MON-0025622

About the designated centre

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

This centre is located in a residential area on the outskirts of the busy town; the location facilitates access to a range of services, shops and recreational opportunities. The premises is a bungalow type residence consisting of 2 distinct units respectively known as 'The Front House' and 'The Apartment'. The front house provides accommodation for two residents and one resident resides in the apartment. The centre operates fifty-two weeks of the year providing wraparound residential and day supports for residents with low to high support needs in the context of their disability and other needs such as physical and health needs. The services and supports provided are based on the principals of individualised service design and are tailored specifically to meet individual needs as identified by the person-centred planning process. Residents are supported by a staff team comprised of social care workers and support workers. Management, oversight and the general operation of the centre is provided for by the social care workers and the person in charge who has overall responsibility for the day to day management of the service.

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 - 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
Tuesday 18 February 2020	09:45hrs to 17:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was unannounced and based on guidance from staff as to the assessed needs and wishes of residents on the day, the inspection was limited to the main house where two of the three residents resided. Both of these residents issued a warm welcome and invited the inspector to have some refreshments with them. What was evident during this initial meeting was how staff effectively communicated with residents; for example in relation to the guidelines for greeting visitors. Residents communicated by gesture and it was evident that they understood that the inspector was in their home for the purpose of work; the inspector also showed one resident her photo identification to further explain her presence in the house. One resident left the house with staff as planned, while the other resident guided the inspector to the kitchen table where staff supported the resident to prepare some refreshments.

During the day, one resident rested and staff were noted to be mindful of this need for rest while attentive to the resident's overall well-being. Staff said that the resident had had a busy few days with community events; staff were present and supportive and aware of the impact of this tiredness, for example on the resident's mobility. The other resident returned to the house in the afternoon and when asked by the inspector how their day was going the resident gave a firm handshake and a thumbs up sign to the inspector.

The inspector noted that there was a relaxed atmosphere in the house and residents were confident in their environment and with staff. Residents were seen to have access as they wished to all areas of their home and could if they wished control their own personal space by locking their bedroom door. Staff on duty were very familiar with the residents, their assessed needs and their required supports and engaged confidently and competently with the inspector.

Capacity and capability

There were many factors that supported good governance. For example, there was an experienced management team, a focus on residents and a staff team who raised concerns and advocated for a better service for residents; staff said that they were listened to and concerns were escalated appropriately by the person in charge to senior management. However, the inspector found that while the provider self-identified or was advised of matters that were impacting negatively on the quality and safety of the service, the action taken by the provider in response was not always timely. In addition while there were many examples of regular and effective systems of review and oversight, some processes did not support robust and effective oversight, so as to assure the provider as to the appropriateness, safety

and quality of the service provided.

The management structure was clear, the provider had appointed suitable persons to participate in the management of the centre, there was evidence of effective communication, appropriate delegation and supportive working relationships. Front-line staff told the inspector that the person in charge was always available, was proactive and responsive to their queries and regular staff meetings were held. The person in charge was also person in charge for two other designated centres, but was satisfied that the practical support needed to ensure effective governance was in place from the social care workers in each of these centres. The person in charge also had access as needed to her manager and the inspector found that all grades of staff were informed as to the operation of the centre, residents lives and matters that needed to be addressed to provide residents with the best possible service. The social care workers met with were clear as to their roles and responsibilities and the day-to-day management of the service. Formal systems of supervision to support staff in their work were operated for all grades of staff and the person in charge who had an office nearby maintained an active presence in the house.

The provider facilitated staff to complete education and training that was needed for them to provide residents with safe, effective support. Staff attendance including attendance at refresher training was monitored and there were no gaps in attendance based on the inspector's review of the training matrix; staff also confirmed their attendance at training. Reflective practice sessions facilitated by an external party were also provided for staff to support them in their work.

There was evidence that the provider acknowledged and sought to address staffing deficits. Additional staff resources were now in place six days each week and staff described the positive impact of this on resident overall well-being and on their quality of life, for example their increased ability to access and engage in the community. The planning of the staff rota did provide for consistency; two rotas were maintained one for the main house and one for the apartment; five regular staff worked in the apartment and eight in the main house. Staff also said that the team worked flexibly as needed and supported residents to attend evening events as they wished. However, while records seen and staff spoken with indicated that day time staffing levels were now adequate it had taken sometime to achieve and establish the staffing levels needed to meet residents' needs. There was evidence that the provider needed to review and decide if the night-time sleepover staff arrangement was suited to resident needs. Staff were formally logging the night-time sleepover routine; these were good records that supported meaningful analysis as they differentiated between for example disturbance of staff sleeping perhaps due to noise and staff getting up to provide residents with assistance and support. The records seen by the inspector indicated that sleepover staff were regularly disturbed due to residents requiring direct support from staff. Staff advised that these monitoring records were being completed for approximately twelve months; this would support the inspection finding that while the provider did respond, responses were not always timely.

The inspector reviewed the reports of the annual review and the two unannounced reviews of the quality and safety of the service completed by the provider for 2019.

There was an additional service review designed to monitor the progress of the quality improvement plans that were issued from all reviews. The inspector noted that the timing of the unannounced reviews did not support consistent monitoring as they had not been completed on a six-monthly basis; both had been completed between September 2019 and January 2020; there was no six monthly review between December 2018 and September 2019.

The reviews did seek feedback from residents, their representatives and staff. The findings were transparent and the provider did identify and accept that there were matters that if addressed would improve the quality and safety of the service such as the need for regular relief staff and a final decision on the suitability of the sleepover staffing arrangement as discussed above. However, in addition to the element of timeliness there was no final solution to these matters; the concerns in relation to the sleepover staffing arrangements were cited in the 2018 annual review and escalated at that time to senior management. However, this issue was again highlighted in the most recent January 2020 review, with the provider's recommended action to continue to monitor the situation.

A recent template circulated to staff for completion to establish compliance with fire safety requirements was not delegated to persons with the required technical knowledge and therefore did not contribute in a meaningful way to effective monitoring.

There were examples of good and effective oversight that supported learning and improved quality and safety such as the reviews held each quarter of any incidents and accidents that occurred in the centre. The management of each incident was reviewed; discussion, feedback and shared learning took place at the staff meetings. There was a good link between these reviews and risk management processes.

The inspector was advised that there was a low level of complaints and no recent complaint; staff understood the complaints management procedure. Representatives were consulted with, for example to inform the reviews discussed above and during the six monthly reviews of the personal plan; the feedback provided was positive and complimentary. Staff described how by gesture or behaviour residents would express their dissatisfaction or unhappiness.

Regulation 14: Persons in charge

The person in charge met the requirements of the regulations and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge facilitated the inspection with ease and had sound knowledge of residents' needs and their required support and of the general operation and management of the service.

Judgment: Compliant

Regulation 15: Staffing

The provider needed to review and decide if the night-time sleepover staff arrangement was suited to resident needs. Records seen by the inspector indicated that sleepover staff were regularly disturbed at night due to residents requiring direct support from staff; this support was provided as needed. Monitoring so as to establish the suitability of this staffing arrangement was ongoing for sometime without a resolution.

Consistency of staffing was largely provided for, but the provider itself had identified a requirement for regular relief staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to mandatory, required and desired training such as safeguarding, fire safety, responding to behaviour of concern and the administration of medicines including medicine that may be required in response to a clinical emergency.

Judgment: Compliant

Regulation 21: Records

Some records related to the care and support provided to residents were not created in a way that their content, meaning and context was clearly retrieved and understood from reading of the record. They were not created in a way that they could be used to monitor adherence to guidance that was in place.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were many factors that supported good governance. However, the inspector found that while the provider self-identified or was advised of matters that were impacting negatively on the quality and safety of the service, the provider's actions in response were not always timely. In addition, while there were many examples of regular and effective systems of review and oversight, some processes did not

support robust and effective oversight so as to assure the provider as to the appropriateness, safety and quality of the service provided. For example, the gap in the timing of the unannounced reviews, the delegation of reviews, records, oversight of restrictive practices and of risk based protocols as discussed in the second section of this report.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider kept the statement of purpose and function under review. The record was seen to contain the required information such as management and staffing arrangements, the facilities provided and how to make a complaint. The statement of purpose was available in the centre and staff confirmed that a copy had been given to residents representatives.

Judgment: Compliant

Regulation 31: Notification of incidents

There were good systems for recording and reviewing incidents and accidents that had occurred in the centre. The person in charge ensured that incidents were notified to the Chief Inspector as and when required, for example any injury sustained by a resident.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider and staff actively sought feedback from residents and their representatives and used this feedback to inform its own reviews of the quality and safety of the service. Staff said that through discussion and the use of accessible materials residents were made aware of the complaint policy and procedures and how to access and use them if needed.

Judgment: Compliant

Quality and safety

Overall this centre was operated in an individualised manner for example the separation of the centre into two distinct areas and largely separate staffing arrangements; this reflected the divergent needs of the three residents living in the centre. As discussed in the first section of this report the centre had not always been resourced so as to provide residents with the best possible care and support. Staff spoken with clearly understood the limitations that this had placed on residents' routines and choices, were satisfied that this was now addressed and staff clearly described the positive impact on residents and their quality of life as a result. However, based on these inspection findings to assure the quality and safety of the service and to continuously improve residents' quality of life further improvement was needed. For example, while there was good awareness and efforts to reduce impact, the provider needed to look at how it reviewed the use of restrictive practices so that the review focused on individual rights, experiences and impacts. In addition there were complex, challenging needs and associated risk in response to which the provider had implemented a specific plan and protocol. The provider needed to review and assure itself as to how it monitored the implementation of this protocol; this monitoring was necessary to ensure and assure adherence to, the impact of and the effectiveness of this protocol.

Staff spoken with were very informed as to residents, their needs and preferences; this knowledge was reflected in the personal plan reviewed by the inspector. Residents and as appropriate their representatives were consulted with in relation to the support that they needed and the review of their plan. Personal goals were linked to assessment; some goals were functional, but still sought to promote resident well-being and development. It was evident that the multi-disciplinary team inputted into the care and support that was provided and the review of its effectiveness. Where community based resources or other agencies inputted into the care and support provided staff had established links so that there was continuity and communication that supported resident well-being.

Residents received what the provider described as a wraparound service where their day and residential service was provided from their home. Residents dependent on the level of assessed risk accessed community facilities independently or with staff. Residents enjoyed attending sporting events, one resident currently had a public exhibition of his art work in a local museum. The garden included a raised bed area where residents and staff cultivated vegetables. Residents liked being out and about going to the shops and other facilities; staff described the local community as respectful and protective of the residents.

Residents were very individual; staff said that the residents in the main house and the apartment very rarely met and this suited both groups of residents. The residents in the main house also had differing needs; this and inadequate staffing levels had in past placed limitations on resident routines and choices as one resident required one-to-one staff support and lived a different pace of life. This was resolved with positive impact, but a residual issue were restrictions that were needed for the safety of one resident but not the other. For example it was necessary to restrict access to cooking utensils and all main doors were locked due

to one resident's needs and their inability to safely access the community without staff. The other resident could and did access the community with and without staff, but other risks such as the risk posed to their peer by perhaps forgetting to lock the door when leaving, meant the restrictions applied to both residents. This was acknowledged in risk assessments and restrictive practice records, there was regular review of these practices and where possible the impact of the restriction was reduced for example by providing the resident with a key to access the kettle; the enhanced staffing greatly increased opportunities to leave the house.The provider's system for reviewing restrictive practices; however, needed to ask what further alternatives were possible, was the restriction the least restrictive option with the ultimate goal of ensuring that residents were safe, but not subject to restrictions not needed for their own specific needs and safety.

There were times when residents assessed needs included behaviour that was challenging, created risk and was directed particularly but not exclusively towards staff. The provider had managed the risk that was posed to peers by the provision of separate living spaces, separate routines and the creation of separate gardens. Staff said that these arrangements suited all residents and residents respected each others boundaries. All staff had completed safeguarding training, the designated safeguarding officer visited the centre and inputted as appropriate into the review of the care and support provided to residents.

The inspector saw that residents with behaviour support needs had access to the clinical supports that they needed including access to the local mental health team, counselling services, psychology and behaviour specialist. Practice in response to these behaviour support needs was guided by a positive behaviour support plan; the plan was clear on the type and possible reasons for the behaviour that was expressed. In addition to the behaviour support plan and associated risk assessments there was a linked protocol that guided times when the response to these behaviours was that staff and the resident disengaged from the other. The protocol was clear on the implementation of disengagement as initiated by the resident by choice or by staff on the basis of risk and set clear benchmarks so that there were structured evident boundaries. Based on the guidelines seen a monitoring tool was to be used to record all instances of disengagement. However, given that disengagement equated to periods where direct staff support was not received either because it was not welcomed or it was not safe for staff, the inspector was not assured by the standard of the monitoring records seen. The reason and who initiated the disengagement was not always clear, nor was the effect or the time-frame. This standard did not lend itself to effective monitoring of adherence to the plan and the protocol or meaningful evaluation by the provider of the appropriateness, the effectiveness and impacts of the protocol.

Staff spoken with had a good understanding of safe medicines practice. Medicines were supplied by a community based pharmacist and residents could based on an assessment of risk and choice manage their own medicines. Reasonable controls were implemented by staff to ensure the safety of this for example by managing the number of medicines available and the use of a dispensing device. The review of incidents included the review of any medicines related incident; based on the records seen by the inspector the incidence of these was low and did not pose a risk

to resident safety.

The provider had fire safety arrangements that promoted resident safety. The front house and the apartment were equipped with an linked fire detection and alarm system, emergency lighting and fire fighting equipment; these were inspected and maintained at the required intervals. The equipment incorporated devices that reflected residents sensory needs such as vibrating devices and lighting to alert residents when the alarm was activated. All staff had completed fire safety training and completed simulated evacuation drills with the residents; these drills replicated possible evacuation scenarios such as maximum occupancy and minimum staffing levels. Any possibility that a resident may not evacuate was reflected in the risk register and in the personal emergency evacuation plan (PEEP). Staff worked with residents to increase their understanding of the importance of evacuating and residents had engaged with this learning process. Doors designed to contain fire and its products were provided for, however only two of these doors were fitted with a device to automatically close them in the event of fire.

As discussed above in the context of needs including behaviour support needs, risk identification and management was core to the safety of both residents and staff. A comprehensive risk register was maintained; front-line staff, the person in charge and senior management all inputted into the management and review of risks. The sample of risk assessments reviewed by the inspector reflected the assessed needs of the residents and the range of needs and challenges that presented in the centre. The review of incidents and accidents informed the review of risk assessments and where situations or circumstances changed this led to a review of the risk assessment and controls were either reduced or enhanced.

Regulation 10: Communication

Residents did have sensory needs and communication differences. The inspector saw that staff supported residents to communicate as they wished and to communicate effectively. For example, one resident preferred to use a series of manual signs and gestures personal to them as opposed to standardised manual signing as they were easily and widely understood . Staff also used a visual staff rota and visuals to communicate choices and planned activities; residents engaged with these tools.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to enjoy a range of meaningful activities and programmes in their home and in the community. Residents were supported to develop and

maintain friendships and relationships.

Judgment: Compliant

Regulation 17: Premises

The inspector could only review the front house. It was homely, safe and comfortable. The house had been refurbished extensively in 2018 and work had been completed to provide a pleasant safe and accessible outdoor space. However, this is not a recently constructed house and some areas though not at a level of non-compliance, were indicating that they would again shortly need attention and redecorating.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety was compromised. The approach to risk management was individualised, dynamic and responsive. Where possible the provider supported responsible risk taking as a means of enhancing quality of life while keeping residents safe from harm.

Judgment: Compliant

Regulation 28: Fire precautions

Doors designed to contain fire and its products were provided for, however only two of these doors were fitted with a device to automatically close them in the event of fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had policy and procedures that sought to ensure that resident health and well-being was promoted and protected by safe medicines management

practice.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan which detailed their needs, abilities and preferences; the plan outlined the care and support required to maintain and maximise resident well-being and quality of life. The plan was developed and kept under review in consultation with the resident and their representative as appropriate and in accordance with their wishes.

Judgment: Compliant

Regulation 7: Positive behavioural support

While there was good awareness and evidence of efforts to reduce impact, the provider needed to look at how it reviewed the use of restrictive practices so that the review focused on individual rights, experiences and impacts particularly where a restriction needed for the safety of one resident impacted on another resident though the restrictions were not necessary for their safety.

The reason why disengagement in response to behaviour of concern and risk was initiated was not always clear, nor was the effect or the time-frame. This did not lend itself to effective monitoring or meaningful evaluation so that the provider could assure itself as to the appropriateness, the effectiveness and the impacts of the intervention.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had policies and procedures that sought to protect residents from all forms of abuse and harm. There were no identified safeguarding concerns in the centre at the time of this inspection.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for The Ash OSV-0004759

Inspection ID: MON-0025622

Date of inspection: 18/02/2020

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Regulation 15 (1): The registered provider shall insure 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; The PIC has reviewed and sent a proposal to the Senior Management team highlighting the required staffing arrangements to suit the resident's needs. Senior Management have agreed to address and work towards implementing the required staffing arrangements to suit the needs of the residents. The proposed change in the service delivery will be discussed with the team to ensure staff consultation. Any additional staffing resources that will be required will be identified and recruited as per the organizational policies and procedures.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 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. The PIC liaised with an external consultant who currently provides supportive sessions for the team and a sample number of support note records were viewed. This was	

discussed as part of the team session on the 10th March 2020.

A recording/monitoring log has been implemented, to record the type of support provided to meet fundamental needs at any time. Each incident of a transition from direct support to indirect support will also be accompanied by a monitoring service log to record the communication that occurs throughout the monitoring period. This will commence immediately and be reviewed for its effectiveness throughout the year. The behavior support specialist will also recommence graphing the instances of the nature of the support provided changing, to provide oversight and ongoing review.

23 March 2020

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
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 resident's needs, consistent and effectively monitored.

The schedule for the unannounced provider lead audits has been discussed at Senior Management level and will ensure that the timing of the 2020 audit will take place in a structured and timely manner.

As outlined in this action plan under Regulation 15 Staffing and Regulation 21 Records processes have been discussed and are to be implemented to ensure compliance.

31/12/2020

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.

The PIC has identified the number of doors which require self-closure devices to be installed. A Risk Assessment has been completed to identify the specific door closures

which are required on each door i.e. acoustic closures or non-acoustic. PIC is awaiting correspondence from the registered company who currently carry out the servicing and testing of the Fire alarm panel at present in the centre, regarding the cost and timeline for works to be carried out.

01/09/2020

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;

The PIC, in consultation with the multidisciplinary support including Social Work, Psychology, Behavior Support, a Senior Management representative and an external consultant, as well as staff have agreed to log ongoing resident feedback relating to the specific protocol in place for supporting the primary emotional, mental and physical needs of the individual. An easy read protocol in already in place and made available and weekly meetings are held to discuss service provision and any incidents which occurred. These are records that are available for review. These weekly meetings are tailored to meet individual needs of as the standard planning meeting process adopted is not in line with individual wishes. The Behavior support specialist also prepared a summary document which includes direct resident feedback relating to the need for tailoring support to meet the individual need and previous interventions that were used by the staff team and were not deemed beneficial.

23/03/2020

Regulation 7 (4): The registered provider shall ensure that, where restrictive practice procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.

The PIC will review all restrictive practices in the centre and assess if any can be reduced in accordance with the needs of all individuals. The restrictive practice protocol in place will be edited to review the number of times the restriction was required in the previous quarter and what efforts can be made to further reduce the restrictions.

30/04/2020

The service provider is acutely aware of individual impact as a result of the safety needs of peers however all efforts are being made to ensure that this impact is the least

restrictive that it can be, as outlined above. The long term compatibility placement of residents will be kept under ongoing review and alternatives will be explored.

01/03/2021

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	31/12/2020
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	23/03/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	31/12/2020

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	01/09/2020
Regulation 07(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 personal planning process.	Substantially Compliant	Yellow	23/03/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	01/03/2021