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:	Bramble House
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	18 February 2020
Centre ID:	OSV-0005692
Fieldwork ID:	MON-0023624

About the designated centre

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

Bramble house designated centre provides community based living arrangements for up to three adult residents of male gender only. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and assign two staff to work in the centre during the day with a third staff available to support residents in having a full and active life. One waking night staff works in this centre at night time. A full-time person in charge is assigned to this centre. The centre is supplied with one transport vehicle to support residents' community based activities. A large secure garden space is situated to the rear of the property. Each resident has their own bedroom.

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	09:00hrs to 17:00hrs	Laura O'Sullivan	Lead
Tuesday 18 February 2020	09:00hrs to 17:00hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

The inspector had the opportunity to meet with the three residents currently residing in Bramble House. Residents appeared very comfortable in their home and had their favorite room and seats to spend time in. Residents were aware of each other and were respectful to the needs of each other. They partook in jovial engagements with each other. For example, one resident liked to place his football in a spot in one of the living rooms, another would move this with both residents laughing.

One resident upon awakening sat on the couch in the living room, due to a visual impairment staff said good morning and introduced themselves to him letting him know who was in the room. They also ensured to introduce both inspectors. The gentleman requested the inspector to sit with him and showed them his favorite comfort item. This resident enjoyed having new people in his house and as such, he didn't wanted to leave. He enjoyed interacting with staff and the inspectors in a fun-loving manner. Staff did encourage the resident to participate in their daily activities but respected the resident's choice to remain in the house on the day of inspection.

One resident was up and about on the arrival of the inspectors. They were relaxing in the living room. They spent much of the morning going between both living rooms. They were observed to be encouraged by a staff member to assist in their laundry that morning. Activation for this resident did not commence until after their lunch when they went for a social outing with one of their peers. This peer had remained in bed until near lunch. Upon awakening after lunch this resident joined his peer in the social outing,

Interactions observed between staff and residents were observed to be positive and respectful in nature.

Capacity and capability

The inspectors reviewed the capacity and capability of Bramble house and overall observed the registered provider was striving to promote a safe effective service for residents. Whilst a clear governance structure had been allocated to the centre, improvements were required to ensure the centre was compliant with the regulations. This inspection was being completed to determine the renewal of registration for the designated centre.

A suitably qualified and experienced individual had been appointed to the role of person in charge to the centre. This person had been allocated governance

oversight to three designated centers within the organization. At present there was no evidence to show that this remit resulted in a negative outcome for Bramble House. The person in charge possessed a keen awareness to the supports needs of the residents and the needs of the service. This person had a reporting role to the community service manager in their person participating in management role. The person participating in management had been appointed to the centre in the previous two weeks. However, this person clearly articulated their governance role within the centre including their responsibilities and accountability.

At organizational level the registered provider had ensured the implementation of the regulatory required monitoring systems. This included the annual review of service provision and six monthly unannounced visits to the centre. Whilst reports generated post the monitoring systems were comprehensive and incorporated consultation with residents action plans were not effective. Actions required were not time bound and were set as being ongoing with no clear end date for actions to be completed. The registered provider had self-identified with organizational audits that it was felt the resident's quality of life would benefit from a larger premises. This was first identified in April 2019. No actions had been completed to further assess or identify a solution to the issues.

At centre level an audit schedule was in in place to guide staff on the requirement of the completion of monitoring systems to maintain oversight. The person in charge maintained oversight of this including adherence to any developed actions plans. Such monitoring incorporated such areas such as personal plans, training and hygiene.

The registered provider had ensured the staffing allocated to the centre was appropriate to the current assessed needs of the residents. Staffing levels in the centre ensured that residents could be supported to participate in a range of meaningful activities if facilitated by staff on duty. The registered provider had ensured that a policy had been developed to support staff and facilitate engagement in quality conversations. However, the person in charge reported that these conversations were not occurring on a 6 weekly basis in accordance with guidelines of the policy. Staff were supported to attend monthly team meetings within the centre.

Staff training records were available to view in the designated centre on the day of the inspection. This included records for identified mandatory and house specific training including Medication Management, Fire Safety Training and Epilepsy Awareness training. The person in charge had ensured that training needs for staff were appropriately identified and planned for. However, on the day of the inspection some mandatory and house specific training was not in date. Two staff were identified as having out of date Medication Management training since December 2019 due to a cancelled refresher training session. Refresher training had been arranged but these staff members were continuing to administer medication in the interim period. The person in charge was unable to provide inspectors with training records for agency staff carrying out lone working duties in the centre. Inspectors were not assured that agency staff employed had completed all required mandatory training or had all of their training needs identified and

met.

The registered provider had not ensured a clear and effective complaints procedure was in place. Two differing versions of the organizational complaints procedure were accessible within the centre. A complaints folder was in place within the centre which was to be utilized to maintain a log of all complaints, concerns and compliments within the centre. However, upon review information present was not up to date and did not reflect the current status of the complaint. It was not clear from documentation maintained if the complaint was resolved or if the complainant was satisfied with the outcome.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the staffing allocated to the centre was appropriate to the needs of the service users.

Nursing care was afforded as required. An actual and planned rota was in place and maintained by the person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that all staff, including agency staff, had access to appropriate training, including refresher training.

Staff were not adequately supervised in accordance with the organisational policy.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents within the designated centre. This included the required details such as the date of admission of residents to the centre, residents' next of kin and contact details and a picture of each resident of the centre.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had ensured the centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had allocated a clear governance structure to the centre. Regulatory required monitoring systems had been implemented however, where actions had been identified plans had not been implemented to ensure these were addressed in a timely manner.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was in place that contained all of the required information such as the organisational structure for the centre, the total staffing complement for the centre, and the arrangements made for dealing with reviews and development of a resident's personal plan. Recent changes to the organisational structure for the centre had been identified in this version of the statement of purpose dated 13 February 2020.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all required incident were notified in accordance with regulatory requirements.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had not ensured a clear and effective complaints procedure was in place. Two differing versions of the organizational complaints procedure were accessible within the centre.

From records maintained within the centre it was not clear that the complaint process was adhered including the satisfaction of the complainant.

Judgment: Not compliant

Quality and safety

The inspectors reviewed the quality and safety of the service afforded to residents within Bramble House. Whilst a homely and respectful home was evidenced a number of improvements were required to ensure compliance with the regulations and the promotion of a safe and effective service.

Throughout the inspection, staff were observed to communicate warmly with residents and there was an obvious rapport evident. Residents were spoken to, and of, respectfully by all staff present on the day of the inspection. Communication passports were in place for each resident. Staff on duty demonstrated a good awareness of the communication needs of resident's, including their individual preferences. For example, one resident had a particular preference involving their intimate care routine. Staff spoke to one inspector of how they would complete this routine and the type of communication preferred by the resident to achieve success in this activity of daily living. Another resident liked to have the radio on in certain rooms at a low volume level. This was noted to be facilitated by the staff on duty throughout the day of the inspection. Each resident had their own tablet device and the person in charge indicated that these were used for weekly residents meeting and occasionally to access music streaming applications. Staff reported that the residents in this designated centre tended to prefer alternative multimedia such as the radio and television. Staff spoken to were knowledgeable about these preferences. Wireless Internet connectivity was provided and a smart TV was available in the main living room of the designated centre. Talking tiles were in place at the entrance to all of the rooms in the centre to assist one resident with

a visual impairment.

The person in charge had ensured that each individual had a comprehensive personal plan in place. This provided staff with clear guidance on support needs of residents and incorporated monthly review of all support needs. An active folder was in place to communicate and address the daily needs of residents. Whilst an annual multidisciplinary review was completed an annual visioning meeting had not occurred for all residents to ensure personal goals reflected the aspirations of each individual. The person in charge did inform inspectors during feedback that one meeting had occurred but this was not presented during the inspection and was not present within the personal plan.

The staff roster was developed to ensure residents were supported to participate in a range of meaningful activities and to develop links within the local community. This was not observed to occur during the inspection. Activation did not occur until after lunch. The culture within the centre was not cognisant to the promotion of residents fulfilling their full potential within the home and the local community.

The registered provider had ensured residents were supported to be safe from abuse. Inspectors viewed the records relating to safeguarding in the centre. These included a log of safeguarding incidents, preliminary screenings and the safeguarding plans in place. There were two open safeguarding concerns on the day of the inspection. The person in charge told inspectors that she had arranged to meet the designated officer on the day following the inspection with a view to closing both of these. This was confirmed post inspection. Comprehensive intimate care plans were in place for residents to ensure residents personal care was afforded in a dignified and respectful manner. Residents appeared happy and comfortable in their home and in the presence of the staff on duty on the day of the inspection.

The registered provider had ensured effective systems were in place for the ongoing identification, monitoring and review of risk. Through the use of risk register effective control measures were in place to reduce the likelihood and impact of identified risk. Corresponding standard operating procedures had been developed to ensure adherence and knowledge sharing of control measures. However, guidance set out to address the risk relating to evacuation of the centre had not been trialled to ensure its effectiveness.

Overall within the centre the registered provider had ensured effective fire management systems were in place within the centre. Staff completed regular checks to ensure that all firefighting equipment in place was in working order and all fire exits were clear. Whilst fire evacuation drills were completed on regular basis by staff incorporating a number of scenarios improvements were required to ensure that all residents were supported to evacuate to a safe area in an effective manner at all times. This was also to incorporate guidance for staff on all situations which had been identified. Whilst effective measures were in place with respect to detection and containment of fire within the immediate living area of the centre it was identified on the day of inspection that the systems in place within an external shed required review to ensure staff and residents could be alerted in an emergency

situation. On the day of inspection the registered provider assured inspectors that a full review of the area would be completed by a competent person.

Regulation 10: Communication

The communication needs of residents had been assessed and were being met. The registered provider had ensured that residents had access to a telephone and appropriate media and that residents were facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Judgment: Compliant

Regulation 13: General welfare and development

The culture within the centre was not cognisant to the promotion of residents fulfilling their full potential within the home and the local community.

Judgment: Not compliant

Regulation 17: Premises

The premises present a warm and homely environment incorporating two living areas and a fully equipped kitchen. Each resident had their own personal bedroom which they were assisted to decorate.

The registered provider had self-identified that the design and layout of the premises did not meet the current objective of the service.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect of the designated centre and this was available to view by the inspectors in the designated centre. This contained the required information including details about the services and facilities provided in the designated centre, the arrangements for resident involvement in the

running of the centre, and the arrangements for visits. Each resident had a copy available to them in accessible format on their own tablet device.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured effective systems were in place for the ongoing identification, monitoring and review of risk. Through the use of risk register effective control measures were in place to reduce the likelihood and impact of identified risk. However, guidance set out to address the risk relating to evacuation had not been trialled to ensure its effectiveness.

Processes and procedures relating to risk were clearly set out in an organisational risk management policy, which also contained the regulatory required information.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The centre overall presented as clean and tidy. A cleaning schedule was in place and adhered to by staff, however this schedule did not incorporate all areas of cleaning required.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were required with respect to the detection of fire the centre. Further enhancements were required with respect to the safe evacuation of all residents to ensure an effective procedure was in place and known to all.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured the designated centre had appropriate and suitable practices relating to the ordering, receipt, prescribing, storage and

administration of medicinal products.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that each individual had a comprehensive personal plan in place. This provided staff with clear guidance on support needs of residents and incorporated monthly review.

Whilst an annual multidisciplinary review was completed an annual visioning meeting had not occurred for all residents to ensure personal goals reflected the aspirations of each individual.

Judgment: Not compliant

Regulation 6: Health care

Whilst overall residents were supported to achieve and maintain the best possible physical and mental health, it was difficult to ascertain the most relevant guidance and recommendations within the personal plans.

Judgment: Substantially compliant

Regulation 8: Protection

The registered provider had ensured that each resident was assisted to protect themselves from abuse. Where a safeguarding concern was identified, measures were implemented to protect the individual from all forms of abuse.

The personal and intimate care needs of all residents was laid out in personal plans in a dignified and respectful manner.

Judgment: Compliant

Regulation 9: Residents' rights

The centre operated in a manner which respected the privacy and dignity to ensure

were consulted and supported to consent to decisions about their care and supports.
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	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bramble House OSV-0005692

Inspection ID: MON-0023624

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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Employees are supported to attend mandatory and mandated training. It is also the responsibility of staff to propose training that would enhance and support their role within St. Patrick's Centre (Kilkenny).

A centre specific training profile, individual staff training profiles and a training schedule are distributed monthly to the PIC and PPIM of the centre by the Training Department. Staff training is on the agenda of the monthly team meetings and also discussed at Quality Conversations.

Following update regarding training in Bramble House:
• One employee is attending Fire refresher training on the 30/03/2020.
• All employees have completed Epilepsy & Buccal training by 28/04/2020.
• All employees have completed medication administration by the 18/04/2020.
• Two employees are booked for Dysphagia training on the 24/03/2020 and 28/03/2020.

Zero tolerance regarding outstanding training:
As part of the learning from the inspection in Bramble House, the Quality Assurance Group met on the 19/02/2020. At this QA meeting it was discussed with all PIC's and Team Leaders to follow up with their staff teams on outstanding training needs and ensure refresher training is booked in a timely manner to ensure compliance in regards to training needs.

At the Senior Management Team Meeting on the 11/03/2020 zero tolerance regarding outstanding training of employees was agreed.

Agency staff:
SPC training department has requested all training certificates of agency staff being

utilised by SPC. Training certificates for agency staff will be held central in SPC training department.

Senior Management Team have decided not to utilise agency staff for night duties in designated centres if at all possible. This will reduce the risk of non-medication trained staff lone working. As an additional support the CSM's have reviewed the Standard Operating Procedure for lone working staff to include guidance and procedure for non-medication trained staff.

Layout of training reports:
SPC training department has changed the layout of monthly training reports. Colour codes are
- highlighting outstanding training needs in red.
- highlight in amber when a refresher training will be due for completion.

Quality department has also discussed with SPC training department to amend the layout of training reports to ensure dates are visible at all times.

Quality Conversations:
There is a Quality Conversations policy in place. The policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for staff. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.

The PIC has a schedule for Quality Conversations in place and is completing same on a 6weekly basis with the staff in Bramble House.

The PIC was also attending three training sessions on the 6th and 28th February and 10th March 2020 to build capacity around Leadership and Quality Conversations.

Team Meetings:
The PIC is facilitating learning through monthly team meetings. Regulations and Standards will be part of team meetings to build capacity within the staff team.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC of Bramble House reports directly to the CSM/PPIM, who in turn reports directly to the Director of Service to ensure good governance for Bramble House.

A new CSM was appointed to Bramble House on the 11/02/2020 and was involved in the

inspection that took place. The CSM attended the team meeting in Bramble House on the 26/02/2020 and is supporting the PIC on weekly basis as the need arises.
The PPIM and PIC have monthly to 6 weekly Quality Conversations, which were started on the 13/03/2020. The PPIM and PIC also attend the monthly Cluster meetings.
The PPIM has monthly Quality Conversations with the Director of Service.

Action Plans:
Learning from the inspection regarding the usage and completion of action plans was discussed with all CSM's, PIC's and Team Leaders at Quality Assurance Meeting on the 19/02/2020.

An action plan template is available for all staff on SPC Q drive to document:
- items discussed
- actions
- person assigned responsible and
- clear timeframes for completion of actions.

QA meeting group also discussed action plans to be used as preparations for Quality Conversations to ensure actions are agreed, timeframes set and line managers to follow up on these agreed actions.

Provider audits:
A schedule for completion of annual and six monthly provider audits is in place. To build capacity within the management team, the new CSM is shadowing completion of a provider audit in another designated centre on the 12/03/2020. Going forward the new CSM for Bramble House will complete provider audits within her own cluster.

Based on the completed provider audits the PIC will be developing action plans and delegated duties for the staff team. The PPIM and PIC will follow through on actions through their scheduled Quality Conversations and team meetings with the staff team.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The quality department has now removed the outdated complaints policy. The most current complaints procedure policy is available for all staff members on the SPC Q drive. An Easy Read document is also available for the people supported.

The PIC has updated the complaints log of Bramble House to include all outcomes of complaints/compliments and comments and evidence of procedures being followed.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The PIC and CSM discussed verbal feedback of the HIQA inspection regarding the culture of support in Bramble House with the staff team at the team meeting on the 26/02/2020. The staff team was supported to identify ideas for in house activities and sensory equipment to promote activation for the people supported within their home.

Monthly review of visioning documentation has now been implemented in Bramble House to ensure a review of roles, goals and skills teaching for each person supported. The PIC and staff team are using the roles based planning toolkit as guidance and documentation tool to evidence progress for each person supported.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
At a housing meeting on the 24/02/2020 senior management and operations team discussed suitability of Bramble House property for the people supported. The housing meeting group agreed that there is a preference for a more spacious house for the people supported and it is acknowledged that Bramble House is a private rental agreement – lease for 10 years, therefore structural changes cannot be completed. Incidents in Bramble House have decreased significantly due to change of medication for one of the people supported. Subsequent monitoring and review of incidents indicates a decrease in possession of risk. It was therefore agreed that currently Bramble House is big enough and suitable for the people supported.
SPC housing officer attended a meeting with the local authority on 09/03/2020 to explore the PRA options for all private rental agreements of SPC and source possible exchange that are on offering through the County Council and suitable for the people supported in Bramble House.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk

management procedures:
It was identified at the inspection that the risk relating to one person refusing to leave the house during evacuation had not been trialed and documented in Bramble House.
The PIC has requested the Behaviour Support Specialist to guide the staff team in their approach as to how best support the person living in Bramble House. This support session was scheduled for the 16/03/2020.
The PIC is addressing the staff teams approach towards supporting this person also in team meetings and Quality Conversations.
The PIC has also requested the fire officers to visit Bramble House and give guidance to the staff team in assisting the people supported during a fire evacuation.
A night time fire drill was scheduled for completion on the 19/03/2020 with the responding designated centre. Due to the current guidance regarding COVID-19 the PIC will risk assess the completion of night time fire drill to be carried out with another designated centre on a daily basis. As soon as the drill is carried out the learning of the drill will be documented and discussed.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The SPC cleaning schedule was discussed at the Quality Assurance Meeting. Areas of cleaning, not identified on the schedule in place are not included in the cleaning schedule. Health & Safety Department has sent the updated cleaning schedule to all CSM's, PIC's and Team Leaders to implement in SPC designated centres.

Additional to the updated cleaning schedule the PIC has a shift planner in place to ensure identified duties are completed on each shift suiting the needs of Bramble House and the people supported living there.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Health & Safety department is currently awaiting quotes to install electricity in the garden shed for installation of fire detection equipment.
In the interim domestic alarms have been installed in the garden shed.

A night time fire drill was scheduled for completion on the 19/03/2020 with the responding designated centre. Due to the current guidance regarding COVID-19 the PIC

will risk assess the completion of night time fire drill to be carried out with another designated centre on a daily basis. As soon as the drill is carried out the learning of the drill will be documented and discussed. The PIC has also requested the fire officers to visit Bramble House and give guidance to the staff team in assisting the people supported during a fire evacuation.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
As part of the implementation of the roles based planning toolkit the PIC and staff team have now scheduled monthly visioning review meetings. This will ensure better oversight for the PIC on progress and implementation of visioning, roles and goals for each person supported.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
As part of the QC with the staff team the PIC will address all necessary update of person supported's personal plan documentation.

The PIC has sought clarity regarding an assessment and referral for one person supported. This person has since been referred back to the neurologist by the GP and was also prescribed calcichew to support bone health. A referral has also been made to the occupational therapist to review footwear for the person supported. The PIC is awaiting a date for review of same.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	30/04/2020
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	30/04/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2020
Regulation 16(1)(c)	The person in charge shall	Not Compliant	Orange	30/03/2020

	ensure that staff are informed of the Act and any regulations and standards made under it.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	09/03/2020
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' needs, consistent and effectively monitored.	Not Compliant	Orange	30/03/2020
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	30/03/2020
Regulation 27	The registered provider shall ensure that	Substantially Compliant	Yellow	24/02/2020

	residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	10/03/2020
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	30/03/2020
Regulation 34(2)(a)	The registered provider shall ensure that a person who is not involved in the matters the subject of complaint is nominated to deal with complaints by or on behalf of residents.	Not Compliant	Orange	20/03/2020
Regulation 34(2)(b)	The registered provider shall	Not Compliant	Orange	20/03/2020

	ensure that all complaints are investigated promptly.			
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	20/03/2020
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	15/04/2020
Regulation 05(4)(c)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and	Not Compliant	Orange	15/04/2020

	the nature of his or her disability.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	12/03/2020