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 Fairways
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Offaly
Type of inspection:	Unannounced
Date of inspection:	09 December 2021
Centre ID:	OSV-0003389
Fieldwork ID:	MON-0035101

About the designated centre

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

The Fairways is a designated centre operated by Nua Healthcare Services Limited. This centre is located a few kilometres from a town in Co. Offaly and provides residential care for up to eight male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre can also cater for residents with high support needs, including those with a mental health diagnosis and those requiring behavioural support. The centre comprises of one building, where residents have their own bedroom, en-suite facilities, bathrooms, kitchen and dining areas, sitting rooms, relaxation areas, staff offices and access to a large secure garden area. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 9 December 2021	09:00hrs to 16:45hrs	Anne Marie Byrne	Lead
Friday 10 December 2021	09:30hrs to 14:30hrs	Anne Marie Byrne	Lead
Thursday 9 December 2021	09:00hrs to 16:45hrs	Ivan Cormican	Support
Friday 10 December 2021	09:30hrs to 14:30hrs	Ivan Cormican	Support

What residents told us and what inspectors observed

Over this two day inspection, the inspectors met with six residents, staff members, team leaders and with the person in charge and director of operations for the service. Residents who met with the inspectors said that they were happy with the service they received and staff were found to have a good understanding of residents' needs. The residents who lived here had high support needs, particularly in the areas of behavioural support and safeguarding and required specific staff support with these aspects of their care. Although, pleasant interactions between staff and residents were observed over both days of this inspection, the inspectors found that significant improvements were required to the centre's staffing arrangements to ensure that the service was meeting the assessed needs of residents. This will be discussed in the subsequent sections of this report.

The centre comprised a large two storey house and a separate single storey bungalow, both of which were connected by a glass corridor. Residents had their own bedroom, en-suite facilities, sensory room, large kitchens and dining areas, sitting rooms and staff offices. To the front and rear of the centre, a large enclosed garden space was available for residents to use. The centre was clean, comfortably furnished, well-maintained and decorated for Christmas, which gave it a nice sense of home. There was also an individual apartment, which was located in the single story bungalow and was home to one resident.

One inspector spoke with the resident who occupied this apartment within the centre and they spoke directly with the inspector for a period of time. Their apartment was warm, cosy and had a homely feel to it. This resident had decorated the walls with their own artwork, which they had completed in their day service. They also displayed personal photographs and photographs of various family celebrations, including, a graduation which they had attended with their family. This resident was very proud of their apartment and they told the inspector that they really enjoyed living there. They talked about how they had attended cookery lessons and of how they loved cooking in their apartment. They also discussed their past and they explained how their life had improved since they moved to their new home. This resident also described how staff supported them to visit their family, which was very important to them. They said that they felt safe in their home and that staff were very supportive. Following on from meeting this resident, the inspector reviewed their daily care notes and found that they were living an active lifestyle and were regularly engaging in activities in the local community. For instance, in the month prior to this inspection, they had gone Christmas shopping, were out and about for coffee and dinner, visited family and also went grocery shopping, as and when they needed.

This inspector also spoke with two other residents, with both residents telling the inspector that they liked their home. One resident said that they were well-supported to get out into the community and that they enjoyed shopping and going for coffee. They told the inspector that staff were very nice to them, that they felt

safe and got on well with other residents. The other resident met with an inspector as they were preparing to go shopping to a local town. Although, they said that they liked living in the centre and that staff were nice, they spoke of their future hopes to move into their own independent house.

Staff in the centre took the opportunity to keep residents up-to-date with developments in regards to COVID 19 and also to keep them informed of topics within the centre such fire safety, complaints, satisfaction with the service and safeguarding.

The findings of this inspection will now be discussed in the next two sections of this report.

Capacity and capability

This inspection was conducted following receipt of information regarding concerns in relation to this centre's staffing arrangements. Overall, although inspectors found that residents enjoyed living in this centre, the current staffing arrangement was not in accordance with residents' most up-to-date assessments of need. Of the regulations inspected against as part of this inspection, significant improvements were required to governance and management and to staffing. Furthermore, the deficits found in this centre's staffing arrangements significantly impacted the provider's ability to safely and consistently implement a plan in the area of safeguarding. This inspection also identified where improvements were required to aspects of fire safety, behavioural support and to the centre's statement of purpose.

In the months prior to this inspection, this centre had experienced reduced staffing levels, which had impacted on the provider's ability to consistently provide residents with the number of staff that they required, in accordance with their most up-to-date assessment of need.

This centre provided care and support to residents with significant complex needs, particularly in the areas of behavioural support and safeguarding. Some residents presented with such significant behaviours, that the use of physical restraint was sometimes required to be applied by a prescribed number of staff in order to maintain the resident's safety and the safety of others. Furthermore, safeguarding plans, which were approved by an external support agency providing additional oversight and support to this centre in terms of safeguarding, determined two-to-one staffing was required for one particular resident in order to reduce the likelihood of similar safeguarding incidents re-occurring. These safeguarding plans were developed in response to previous safeguarding incidents which had occurred, to ensure that these residents and those they lived with, were maintained safe at all times. In addition to the aforementioned, in the months prior to this inspection, the provider had completed an assessment of need for each resident, which identified the specific number of staff that each individual resident was required to be supported by, both day and night. Due to the high support needs of these residents,

the outcome of these assessments was integral to guiding the provider as to the specific staff support required within this centre, so as to maintain the safety of each resident and the other residents that they lived with.

As part of this inspection, inspectors reviewed residents' assessments of need, which identified that the provider was not providing staffing resources in line with the staffing requirements outlined within these assessments. For example, one resident was identified in their most up-to-date assessment of need, as requiring a two-to-one staffing arrangement. On both days of this inspection, this staffing arrangement was not in place for them. A review of the roster for the previous two weeks prior to this inspection, also identified other times where adequate day-time staffing levels in accordance with residents' assessed needs was not consistently available. Similar deficits were found with regards to night time staffing arrangements, whereby some residents' assessments of need identified specific night-time staff support and supervision arrangements; however; night time staffing levels didn't always allow for this.

While at the time of inspection, no incident had occurred on foot of these reduced staffing levels, due to the complexity of residents' assessed behavioural and safeguarding needs, the potential impact of these residents not consistently having access to the number of staff that they were assessed as requiring, significantly compromised each resident's safety and the safety of their peers. This failure to provide staffing levels in accordance with residents' assessed needs also posed the potential for increased incidents of a safeguarding nature to occur, which would impact on the safety of service delivered to these residents.

Prior to this inspection, a decision was made by the provider at a senior management level, to implement a reduced staffing arrangement, as a control measure in response to COVID-19. Guidance on this arrangement was requested by inspectors, but they were informed that such guidance had not been made available to the centre. Despite this, inspectors were informed by members of management that this reduced staffing arrangement recommended a specific minimum number of staff that were to be rostered both day and night. However, the provider was unable to demonstrate how this specific reduction in staff numbers was calculated, as a re-assessment of each resident's assessed needs had not been completed to determine that the centre could still safely operate, with this specific reduction in staffing levels, without impacting on the safety of care delivered to residents.

Furthermore, in the absence of this baseline assessment, members of management were not adequately guided on what a safe reduced staffing number for this centre was. Had this been made available to them, it would've better informed and supported them in their on-going review of this centre's staffing arrangement, so that they could effectively monitor against the potential impact posed to individual residents, who were not consistently in receipt of the specific staff support that they were assessed for as requiring.

There was also a lack of guidance on how the reduced staffing level arrangement was to be robustly monitored for potential impact to the safety of service, while minimum staffing levels were in operation. Even though members of management

were actively reviewing the centre's staffing arrangement, as well the lack of guidance available to them on what the assessed baseline reduced staffing level was for this service, they also were not sufficiently guided on what to specifically monitor for, should the centre run into challenges, if times arose where these reduced staffing levels could not be met. For example, a safeguarding plan identified that a resident required two-to-one staffing; however, as a result of reduced staffing levels, this was not provided on a consistent basis and no enhanced monitoring was in place to oversee how often this was occurring, to specifically monitor for the potential impact this may have for this resident and on the overall safeguarding arrangements in the centre. Although the provider's failure to provide this staffing arrangement had not contributed to a negative outcome for this resident to date, given the high support needs of this residents and those that they lived with, it did present with a concern regarding the potential impact to this resident, where they were not consistently receiving the level of staff support that they were assessed as requiring. Similarly, a review of the roster identified times where the centre was challenged to meet the reduced staffing levels as set out by senior management, and there was a lack of enhanced oversight as to how often this was occurring, to monitor for potential impact to the safety and also to the quality of service delivered to other residents.

Even though this provider was very aware of, and was responsive to the current staffing arrangement in this centre, given the high resident support needs in this centre, failure to provide these residents with the staffing levels that they were assessed as requiring, posed a significant potential impact to the safety of service that residents received.

At the time of this inspection, the provider was in the process of recruiting additional staff and a number of new staff members were undergoing induction and were scheduled to commence working in the centre in the coming weeks. In the interim, the provider had put additional measures in place to support this centre's staffing arrangement. During this time, the person in charge, in conjunction with his line manager and team leaders, were reviewing the staffing levels on a daily basis to identify how best to utilise available staffing resources in terms of residents' needs.

There was a statement of purpose available at the centre and although it was recently reviewed, it hadn't been updated to reflect this centre's current staffing arrangement.

Regulation 15: Staffing

The provider had not ensured that the number of staff was appropriate to the assessed needs of residents. For example, where residents were assessed as requiring specific staff support, this was not consistently provided to them in accordance with their most up-to-date assessment of need.

Judgment: Not compliant

Regulation 23: Governance and management

The provider hadn't ensured that this centre was resourced in terms of staffing, to ensure the effective delivery of care and support in accordance with residents' assessed needs. For example, since the introduction of a reduced staffing arrangement in this centre:

- No re-assessment of residents needs had been completed to inform this decision to ensure that the centre could safely operated at a reduced staffing level

- There was no guidance available to support members of management in effectively monitoring for the potential impact to the quality and safety of service delivered to residents, while this minimum staffing arrangement was in place.

Judgment: Not compliant

Regulation 3: Statement of purpose

Although there was a statement of purpose available at the centre, it didn't accurately set out the centre's current staffing arrangement.

Judgment: Substantially compliant

Quality and safety

Overall, the inspectors found that although the provider was not consistently providing staffing in-line with residents' assessed needs which had the potential to negatively impact on the safety and safeguarding of one resident; however, residents who met with the inspectors indicated a high level of satisfaction with the service.

There were a number of active safeguarding plans in place and staff present had a good knowledge of these plans. The provision of adequate staffing in line with the assessed needs of residents underpinned the principle of these safeguarding plans. One safeguarding plan reviewed by inspectors stated that a resident required a two-to-one staffing ratio but the provider was unable to consistently provide this ratio due to reduced staffing levels which were in operation at the time of inspection. Furthermore, this resident was not resourced by the required staffing arrangement

over both days of inspection and a staff member who met with the inspector stated that this was a regular occurrence in this centre. The inspectors found that this staffing issue had the potential to have a negative impact on safeguarding this resident and compromised safety within the centre. In addition, the provider had responded to a recent incident and a referral had been made to an external safeguarding team in line with the centre's safeguarding policy. Although staff were aware of the incident and of the measures which were implemented to protect residents, and the provider had initiated a multidisciplinary team review to safeguard residents; however, there was no interim safeguarding plan in place. This was brought to the attention of management and an interim safeguarding plan was implemented prior to the close of the inspection.

Residents had comprehensive personal plans in place and their assessments of need were updated on an annual basis, which identified residents' individual needs and the level of staff support that they required. The provider had assigned key workers to each resident and formal meetings were held on a monthly basis, where residents choose the goals that they would like to achieve in the upcoming month. For example, one resident had chosen meaningful goals for them, such as, attending cookery classes and doing food shopping for new recipes they had made. They also wanted to learn how to swim and the resident's keyworker was supporting them to join a local leisure club and make arrangements for lessons. The inspectors reviewed another resident's assessment of need, which clearly indicated what was important to them and what interests they had. For this particular resident, it was important to them to stay in contact with their family and the provider ensured that this was occurring on a regular basis. This positive example of care was clearly evident in notes that were taken as part of monthly keyworker meetings. However, some improvements were required, as this resident's interest in comic books had not been explored and their desire to meet up with an old school friend had not been further developed.

Many of these residents led very active lifestyles and a review of daily notes by the inspectors, indicated that these residents were regularly out and about in the local community. The inspectors also observed residents frequently coming and going with staff support on both days of inspection. Although the centre was currently operating at minimum staffing levels, this had resulted in little impact to residents in terms of their social care. A resident who met with one of the inspectors, said that they were aware of the reduction in staff; however, this generally hadn't been a problem for them. They said that occasionally they would miss out on an activity if there were low staff numbers but they didn't mind as generally they were out most days. A review of daily notes for another resident indicated that they required two-to-one staffing and although this level of staff support was not always available to them, this had only resulted in them missing out on one scheduled outing in the previous month. Daily notes also indicated that when residents choose to engage in an activity, it was meaningful for them, such as going to visit their family or engaging in an activity of interest to them.

In light of the reduced staffing levels that were being operated in this centre, the inspectors reviewed a number of fire drill records. These records identified that staff could safely support residents to evacuate the centre in a timely manner and of the

records reviewed, no issues or concerns were raised as a result of the most recent fire drills completed. Although the provider had carried out fire drills using previous minimum staffing levels, since the introduction of reduced staffing levels in this centre, a fire drill using these revised minimum staffing levels had not been completed.

Residents in this centre required interventions in terms of behavioural support and staff who met with the inspectors had a good understanding of residents' behavioural needs. Behavioural support plans were in place to assist staff in this area of care and inspectors reviewed a sample of these plans. Behavioural support plans were found to be reviewed on a regular basis and gave an account of each resident's need. However, plans indicated that some residents should be monitored following behaviour of concerns for a return to a baseline of behaviour, but there was no indication in these support plans as to how these residents would present at baseline. This issue was rectified prior to the close of the inspection. Furthermore, a behavioural support plan indicated that a physical restrictive intervention could be used, should behaviours present as a safety concern. There was clear guidance in place to guide staff with this intervention; however, a review of behavioural related incidents by inspectors, indicated that all aspects of this guidance were not consistently implemented.

Regulation 28: Fire precautions

For the purpose of this inspection, this regulation was not looked at in its entirety.

Fire drills were regularly occurring and records reviewed by the inspectors identified that staff could effectively support residents to evacuate in a timely manner. Although the provider had carried out fire drills using previous minimum staffing levels, since the introduction of reduced staffing levels in this centre, a fire drill using these revised minimum staffing levels had not been completed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had implemented a goal setting process to assist residents in developing their interests and realising their aspirations. However, this process was not effectively implemented and some residents wishes and goals needed to be better explored and progressed.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider failed to ensure that all guidance in relation to behavioural support was utilised prior to the implementation of a physical restrictive practice.

Judgment: Substantially compliant

Regulation 8: Protection

There were a number of active safeguarding plans in place in the centre; however, the provider failed to ensure that a staffing ratio as detailed in a safeguarding plan was consistently implemented which did not ensure the safeguarding of residents and compromised safety within the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for The Fairways OSV-0003389

Inspection ID: MON-0035101

Date of inspection: 10/12/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Person in Charge (PIC) has completed a review of Service User's Comprehensive Needs Assessments. Following this review, the PIC has ensured that staffing levels within the center are in line with the Service User's assessed needs. This review was completed on 5th January 2022. 2. Since the inspection there have been several staff recruited to work in the center which has supported with maintaining staffing levels in line with Service User's assessed needs. The Person in Charge (PIC) and Director of Operations (DOO) continue to review the Centre's recruitment plan on an ongoing basis. 3. Where Minimum staffing levels are required to reduce footfall in the center to meet the services infection prevention and control needs in conjunction with Nua Healthcare's Covid-19 Risk Assessments, staffing levels are reviewed by the Person in Charge (PIC) in conjunction with Director of Operations (DOO) to ensure staffing levels are sufficient to meet the needs and safety of the Service Users. 4. The Statement of Purpose has been reviewed and updated to ensure staffing levels are aligned with the Centre's existing staffing levels and Service User occupancy level, as well as referencing staffing levels at full occupancy. 5. The above points were discussed at the monthly Staff Team Meeting held on 27 January 2022.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Person in Charge (PIC) has completed a review of Service User's Comprehensive Needs Assessments. Following this review, the PIC has ensured that staffing levels within	

the center are in line with the Service User's assessed needs. This review was completed on 5th January 2022.

2. Since the inspection there have been several staff recruited to work in the center which has supported with maintaining staffing levels in line with Service user's assessed needs. The Person in Charge (PIC) and Director of Operations (DOO) continue to review the Centre's recruitment plan on an ongoing basis.

3. Where Minimum staffing levels are required to reduce footfall in the center to meet the services infection prevention and control needs in conjunction with Nua Healthcare's Covid-19 Risk Assessments, staffing levels are reviewed by the Person in Charge (PIC) in conjunction with Director of Operations (DOO) to ensure staffing levels are sufficient to meet the needs and safety of the Service Users.

4. The above points were discussed at the monthly Staff Team Meeting held on 27 January 2022.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
1. The Statement of Purpose has been reviewed and updated to ensure staffing levels are aligned with the Centre's existing staffing levels and Service User occupancy level, as well as referencing staffing levels at full occupancy.

2. The above points were discussed at the monthly Staff Team Meeting held on 27 January 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Person in Charge (PIC) has completed a review of the Designated Centre's fire safety procedures. A Fire drill has been completed with the minimum staffing levels available within the Designated Centre. This fire drill occurred on 26 January 2022 and all Service Users were successfully evacuated within a safe timeframe. An additional fire drill with minimum staffing levels occurred on 29 March 2022 and all Service Users were successfully evacuated within a safe timeframe.

2. The PIC has completed a review of the Service Users – Personal Emergency Evacuation Plans (PEEPS) to ensure all control measures in place are adequate and sufficient to maintain quality and safe care to the Service Users and reflect the staffing levels and arrangements in place in the Centre.

3. The above points are included as a standing agenda at monthly Staff Team Meetings held on 27 January 2022

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
1. The Person in Charge continues to review Service User's Personal Plan's and

Comprehensive Needs Assessments to ensure Service Users goals are continued to be met.

2. The above points are included as a standing agenda at monthly Staff Team Meetings held on 27 January 2022

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Behavioral Specialist in conjunction with the PIC has reviewed and updated where required Service Users Multi-Element Behavior Support Plans (MEBSP) and section 5 of Service Users personal plans. Updated plans have been communicated to the Staff Team and were discussed at monthly team meeting held on 27 January 2022.

2. The Behavioral Specialist attended the Staff Team Meeting on 27 January 2022 to discuss strategies used in dealing with Challenging Behavior. The Behavioral Specialist continues to visit the center on a regular basis to support the staff team with implementing strategies in the Service Users Multi-Element Behavior Support Plans (MEBSP) and their proactive and reactive strategies in their Personal Plans.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Person in Charge (PIC) has completed a review of all 'active' safeguarding plans in the Centre to ensure all control measures in place are adequate and sufficient to maintain quality and safe care to the Service Users and reflect the staffing levels and arrangements in place in the Centre. This review was completed on 10th January 2022.

2. There is a Center Specific Safeguarding Register in the center. This is reviewed and updated by the PIC after any safeguarding concerns.

3. The Designated Safeguarding Officer attends the center on a regular basis to review all "active" safeguarding plans in the center. Additionally, the Designated Safeguarding Officer meets with the Service Users in relation to any safeguarding concerns.

4. There are monthly Safeguarding meetings in the center attended by Designated Safeguarding Officer, PIC, Teal Leader (TL) and Deputy Team Leader (DTL) to discuss "active "safeguarding concerns in the center. Minutes are compiled for these meetings and are shared with the staff team.

5. The Designated Safeguarding Officer attended the Staff Team Meeting on 27 January 2022 to provide further education and training on Safeguarding Vulnerable Persons and to discuss current safeguarding plans in the center

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.	Not Compliant	Orange	27/01/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	27/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Not Compliant	Orange	27/01/2022

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	27/01/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	27/01/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	27/01/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Substantially Compliant	Yellow	27/01/2022

	this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	27/01/2022