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:	Stewarts Care Adult Services Designated Centre 2
Name of provider:	Stewarts Care Limited
Address of centre:	Dublin 20
Type of inspection:	Short Notice Announced
Date of inspection:	24 March 2021
Centre ID:	OSV-0005850
Fieldwork ID:	MON-0032132

About the designated centre

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

Designated Centre 2 is operated by Stewarts Care Limited. This designated centre provides full-time residential services for up to 13 adults with intellectual disabilities. The centre comprises of three residential houses located across two housing estates in Leixlip, Co. Kildare. All houses are within walking distance from each other. Each residential house that comprises the centre is a detached two storey house fitted with a kitchen/dining area, private bedrooms for residents, garden spaces to the rear and a good supply of toilets/showers and ensuite facilities. The centre is managed by a person in charge who reports to a senior manager. The staff team comprises of nurses and healthcare assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 24 March 2021	10:00hrs to 16:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

In line with infection prevention and control guidelines, the inspector carried out the inspection mostly from a room located in one of the residential houses that made up the designated centre. The inspector ensured physical distancing measures and use of personal protective equipment (PPE) was implemented throughout the course of the inspection and during interactions with residents and staff. During the course of the inspection, the inspector visited each residential unit in the centre, for a short period of time, to meet with residents and staff and visually inspect the premises.

Residents in one residential unit were unable to provide feedback about the service and it was noted that the presence of an unfamiliar person could cause difficulties for some residents. In that instance the inspector kept their interactions with residents in that house to a minimum to avoid any disruption to residents. Visual observations of the house demonstrated it was a homely environment and clean throughout. However, some aspects of the premises required refurbishment. For example, the carpet on the stairs was worn and parts of the premises required repainting.

In the second house visited by the inspector, residents spoke with the inspector for a short period of time. Residents were observed colouring and showed the inspector their art work. Residents also showed the inspector some cooking they had done earlier where they had made a Shepard's pie for the house. They told the inspector they enjoyed baking and cooking. The house was observed to be homely, clean, well ventilated and nicely decorated. Residents told the inspector they were looking forward to restrictions lessening as they missed engaging in activities in the community. During the visit, the inspector observed the person in charge discuss with residents social goal planning opportunities based on some suggestions made by residents.

Residents in the third house greeted the inspector and spoke to them briefly also. Residents appeared comfortable in their home and at the time were relaxing in the living room space. Some residents were unable to provide verbal feedback to the inspector, other residents spoke about interests they had which included gardening. Residents were missing their jobs and daily activity programme which had been disrupted by the ongoing public health restrictions. Again the inspector observed the new person in charge take the opportunity to discuss some potential goal setting opportunities with residents during the visit.

The house was homely and overall a pleasant environment for residents with a large garden space to the rear of the property. However, it was observed there was a lack of storage space and part of the staff office was incorporated into a living room space a resident liked to use. The inspector observed the space was somewhat cluttered with storage boxes and shelves with staff files. While the space had been provided with a comfortable seating space it required improvement to ensure it provided a usable space for residents to spend time away alone, or engage in

personal hobbies as they wished.

Some other aspects of the premises in the house also required improvement, it was noted the sofa in the living room required replacing, areas of the premises required repainting also.

In summary, based on the feedback from residents and what the inspector observed, residents living in this designated centre were experiencing a reasonable quality of service provision. This was due to the provider implementing their compliance improvement plan which was aligned to a restrictive condition placed on the registration of this designated centre.

However, considerable improvements were required to the governance and management systems in the centre to bring about compliance with the regulations and to ensure appropriate and adequate oversight and supervision of the staff team working in this centre.

It was noted governance and oversight arrangements for the centre had been inadequate in the months prior to the appointment of the new person in charge.

While it was demonstrated staff had ensured residents' needs were met for the most part, there had been an absence of effective oversight arrangements to ensure residents' assessed needs were reviewed, behaviour support planning arrangements were up-to-date and behavioural incidents of a safeguarding nature were managed in line with the provider's safeguarding vulnerable adults policies and procedures.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to residents living in the centre.

Capacity and capability

Overall, the inspector found the provider had implemented their compliance improvement plan which was aligned to a restrictive condition of their registration. The purpose of the plan was to improve the compliance within the centre by implementing an improvement plan linked to a number of regulations.

However, there had been an absence of a person in charge and centre based oversight of the centre in the months prior to the inspection. This resulted in poor inspection findings across a range of regulations reviewed. While the provider had implemented their improvement plan, the absence of a person in charge to maintain the improvement systems resulted in poor inspection findings on this inspection.

The centre was registered in March 2020 for 13 residents with a restrictive condition placed on the registration linked to the provider's centre improvement plan. The

provider had met the matters of the restrictive condition. However, as discussed, sustained improvement had not been maintained due to the absence of operational management of the centre during the absence of a person in charge.

The provider had completed an annual report for 2020 which met the requirements of the regulations and sought feedback from residents.

While there was evidence of some other quality assurance audits taking place, they had not been effective in providing information about the quality of service in the centre. For example, while the provider had ensured two six-monthly audits had taken place in 2020, the audits had been carried out on both occasions in one of the three houses that made up the centre. Therefore, while audits had been completed they had not reviewed the centre in it's entirety and had focused on only one house in 2020.

In addition, it was not demonstrated ongoing operational management auditing and monitoring systems were in place to review the quality of the service being provided. There was no systematic schedule of audits or quality checks for the person in charge or a centre based team leader to complete. The inspector reviewed this with the newly appointed person in charge of the centre who confirmed this quality oversight arrangement was not currently in place.

As a result the majority of regulatory non-compliance findings on this inspection were directly attributable to the absence of management oversight arrangements in the centre and ongoing consistent quality assurance reviews and monitoring within all parts of the designated centre.

It was noted however, that the provider had recently appointed a new person in charge for the centre. They were found to meet the requirements of regulation 14 and had the required management experience and qualifications to fulfil the post. They had taken up their post approximately two weeks prior to the inspection.

The newly appointed person in charge was a registered nurse and appointed in a full-time position as required by the regulations. They were also responsible for one other designated centre within the organisation.

The inspector observed the person in charge engage in development and goal setting conversations with residents during the course of the inspection which was a positive initiative by them and demonstrated one of their goals for the centre which was to establish residents' social goal opportunities. They also demonstrated a good knowledge of the regulations and an understanding of safeguarding policies and procedures.

However, it was not demonstrated there were adequate governance and management oversight arrangements for the centre in the absence of the person in charge. For example, while the the oversight arrangements for the centre in the absence of the person in charge were to fall under the senior manager, this oversight arrangement had been in place in the months prior to the inspection and had not been effective. It was not demonstrated therefore, that effective deputising arrangements were in place during times when the person in charge was absent or

not present in the centre.

The staff team consisted of nurses and health care assistants. While staff had received mandatory training as required by the regulations, there were gaps in refresher training found across some areas reviewed.

Staff supervision arrangements required considerable improvement. On review of supervision records for staff it was noted staff had not received a supervision meeting with their manager on a consistent basis and in some cases for a considerable period of time. For example, some staff had not received a documented supervision meeting with their manager since 2018, with the most recent supervision meeting for some staff dated April 2020.

The provider's supervision policy and procedures set out that staff should receive a supervision meeting with their manager on a quarterly basis over a year. Overall, this required significant improvement in order to come into compliance with the regulations and to ensure staff were appropriately supported, supervised and managed on a consistent basis.

The inspector reviewed a sample of recorded incidents in the centre. It was noted some behavioural incidents of a safeguarding nature recorded in March 2020 and February 2021 had not been notified to the Chief Inspector as required by the regulations.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the centre. They had ensured the person in charge appointed met the requirements of regulation 14 in relation to experience and qualifications.

Judgment: Compliant

Regulation 16: Training and staff development

Some gaps in refresher training were noted and required improvement.

Staff working in this centre had not been provided with appropriate supervision arrangements. Significant improvements were required to ensure staff received supervision and support by their manager on a regular basis and in line with the provider's supervision policies and procedures.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured consistent management and oversight arrangements in this centre to sustain compliance and supervision arrangements of staff.

A number of regulatory non-compliances found on this inspection were directly attributable to the absence of governance and management oversight arrangements in the centre on a consistent basis.

While the provider had completed two six-monthly audits of the service in 2020, as required by the regulations, the audits had occurred in the same residential unit on both occasions and had not taken into account the centre in it's entirety and were therefore not comprehensive in scope.

There were inadequate arrangements in place to manage the centre during periods when there was an absence of the person in charge.

There was no operational management auditing system in place for the person in charge to complete to ensure consistent review of key quality indicators and compliance in the centre on an ongoing basis.

The provider had completed an annual report of the centre for 2020 which met the requirements of the regulations.

Judgment: Not compliant

Regulation 31: Notification of incidents

Not all required notifications had been submitted to the Chief Inspector within the time-lines as set out in the regulations.

It was noted some behavioural incidents of a safeguarding nature recorded in March 2020 and February 2021 had not been notified to the Chief Inspector.

Judgment: Not compliant

Quality and safety

For the most part the inspector found that residents' well-being and welfare was maintained by a reasonable standard of care and support.

However, considerable improvements were required to the operational governance and management of the centre to ensure the quality and safety of care and support to residents was at it's most optimum and in compliance with the regulations.

Despite the fact that the person in charge was only in post approximately two weeks, they were knowledgeable about the residents and had plans in place to improve the living environment for residents and to promote their social goals and community based activities.

Residents' healthcare plans demonstrated that each resident had access to appropriate allied health professionals such as psychiatry, speech and language therapy and their general practitioners (GP). During the COVID-19 health pandemic, systems were in place to ensure GP visits or appointments were in line with public health guidelines which promoted the safety and well-being of the residents. Residents were also supported to avail of National health-care screening programmes in line with their age and gender. Each resident was also supported to have an annual health check with their GPs.

The provider had put in place safeguarding measures to ensure that staff providing personal intimate care to residents, did so in line with each resident's personal plan and in a manner that respected each resident's privacy and dignity.

However, further improvements were required to ensure residents were appropriately safeguarded through the implementation of safeguarding policies and procedures. The inspector noted two behavioural incidents that had occurred in the previous year that constituted a safeguarding concern. It was not evident that those incidents had been reviewed through the provider's safeguarding procedures.

In addition, while safeguarding planning was in place, those plans had not been reviewed for a considerable period of time to ensure they were up-to-date, provided guidance to staff in how to safeguard residents and ensure they remained effective to manage the safeguarding concern they had initially been drafted to address. All staff had received training in safeguarding vulnerable adults with refresher training dates scheduled.

The centre comprised of three two storey detached houses located across two housing estates within a short distance from each other. Overall, each house was homely, comfortable and well laid out to meet the assessed needs of residents. The inspector observed a good standard of cleanliness in each home. Each resident had their own private bedroom decorated to meet the individual style and preferences of the residents. While each residential home was a pleasant and homely environment for residents, it was noted premises improvements were required across each house in the designated centre to ensure they were maintained to a good standard.

In addition, in one residential house further improvements were required to ensure staff administration space did not impact on residents; communal space. The inspector observed a living room space in one of the houses also incorporated the staff administration space, shelves with administration folders and storage boxes.

Some residents preferred to use this space when they wished to listen to music or

spend time alone. The provider was required to review these matters to ensure residents could comfortably utilise all areas in their home for the purpose of self-directed activities and relaxation whilst also ensuring staff had suitable options to perform their administration duties.

The person in charge had reviewed and updated the risk register for the centre. There was evidence of the provider's risk management policy and procedures being implemented in the centre. However, some improvement was required to ensure safe and appropriate risk management procedures were documented and in place for the administration of some medications that required additional precautions.

Infection prevention and control measures specific to COVID-19 were in place and there was evidence of their implementation in the centre. There were contingency arrangements in place for the centre during the current pandemic and the person in charge had undertaken to create COVID-19 contingency plans for each residential house that made up the centre.

The inspector observed staff wearing appropriate personal protective equipment during the course of the inspection. Residents and staff also received daily temperature checks and alcohol hand gels were made available in the centre. Staff and residents had received COVID-19 vaccinations. Some residents had not consented yet to receive the vaccine and it was noted conversations and discussions were taking place to inform and support those residents in making an informed decision in that regard.

Appropriate fire safety precautions were in place and there was evidence of up-to-date fire safety servicing checks across all residential houses that made up the centre. Appropriate fire containment measures were also in place to contain the spread of fire or smoke. Staff had received fire safety training. A number of staff were required to complete refresher training in fire safety, this finding is incorporated under Regulation 16: Staff training and development. Each resident had an up-to-date personal evacuation plan in place.

While appropriate fire safety prevention and management procedures were in place, some further improvement was required to ensure fire evacuation drills included an assessment of fire safety precautions when staffing levels were at their lowest, which was night time. It was not demonstrated drills had reviewed this aspect of fire safety management from the sample of recorded drills reviewed.

A number of residents living in this designated centre required positive behaviour supports. It was noted those residents had behaviour support planning in place, however significant improvement was required to ensure compliance with the regulations.

The inspector reviewed a sample of behaviour support plans and noted they were out-of-date for a considerable period of time. For example, one behaviour support plan, dated 2016, included only a reactive strategy plan without proactive measures identified to guide staff in how to mitigate and monitor for triggers that could elicit the behaviour and strategies to reduce the likelihood of them occurring. Other plans reviewed were dated 2018. In those plans it was noted they followed a proactive

planning process, but had also not been updated since then.

This required improvement to ensure behaviour support planning provided staff with up-to-date guidance in how to manage residents' behaviour support needs and were reflective of residents' presenting needs within the context of COVID-19 and it's impact on residents.

Overall, there were a relatively low number of restrictive practices used in the centre. Where required they managed a specific personal risk for residents. While there was evidence of proactive measures implemented to support residents availing of health-care interventions, at the time of inspection this process had stopped.

It was not clear what measures were now in place to support some residents to receive health-care interventions in the least restrictive way, given the cessation of this intervention programme.

Regulation 17: Premises

Overall, each residential home that made up the centre was homely, clean and decorated to meet the personal style and preferences of residents. However, improvements were required.

For example:

-The couch in one residential house required replacing as the leather had begun to peel in parts.

- A radiator in one residential house was observed to have a build up of rust.

- Each residential house required repainting of walls in parts

- Staff office files and an administrative work space was located in one living room of a house visited, this arrangement could not provide residents with a comfortable and usable space at all times.

- Carpets were frayed and worn in some residential houses visited.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had ensured a risk management policy that met the requirements of the regulations was in place.

There was evidence of it's implementation in the centre with further evidence that the newly appointed person in charge had reviewed documented risk assessments and updated them as required.

The inspector did note a medication management risk that had not been assessed and required review and risk management control measures put in place to guide staff when administering the medication.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had ensured appropriate infection control measures were in place which were in line with Public Health Guidance.

Infection prevention and control measures specific to COVID-19 were in place and there was evidence of their implementation in the centre. There were contingency arrangements in place for the centre during the current pandemic and the person in charge had undertaken to create COVID-19 contingency plans for each residential house that made up the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured effective fire safety management precautions were in place.

Fire safety equipment had received an up-to-date service across all three houses that comprised the centre. Fire containment measures were also in place and observed throughout each residential house visited.

Fire evacuation drills had been carried out in the centre on regular occasions and each resident had an up-to-date personal evacuation plan in place. However, it was not demonstrated that evacuation procedures with a reduced staff capacity at night time had been adequately assessed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had received a comprehensive assessment of need. Where residents needs were identified support planning arrangements were in place with evidence of allied professional reviews which informed those plans and provided guidance for staff.

While personal plans were comprehensive in nature they required review and updating. All plans reviewed demonstrated gaps where plans had not been updated to reflect current support arrangements for residents.

Judgment: Substantially compliant

Regulation 6: Health care

Each resident had received an annual health check with evidence to demonstrated residents healthcare needs were monitored and reviewed regularly and as required.

Residents had also been afforded the opportunity to avail of National health screening services available to them based on their gender and age.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents living in this designated centre required positive behaviour supports to meet their assessed needs.

While it was demonstrated behaviour support planning arrangements were in place, a number of plans reviewed on inspection were out-of-date for a considerable period of time and required review.

Overall, there were a low number of restrictive practices in place and where required were to manage a specific risk.

A de-sensitization process to support a resident when having blood tests had been implemented, which demonstrated every effort to ensure the least restrictive option was implemented at all times. However, in recent months the programme had ceased. It was not clear what plan was in place to support the resident in this regard.

Judgment: Not compliant

Regulation 8: Protection

While it was demonstrated the provider had put in place appropriate policies and procedures to safeguard residents, it was not demonstrated those procedures were implemented in an effective and consistent manner.

Where some behavioural incidents had negatively impacted on peers and resulted in a safeguarding concern, it was not demonstrated those instances had been reviewed through the provider's safeguarding procedures and referred to a designated person.

A number of safeguarding plans were in place, however, they had not been reviewed for a considerable period of time.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Stewarts Care Adult Services Designated Centre 2 OSV-0005850

Inspection ID: MON-0032132

Date of inspection: 24/03/2021

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1.Monthly Training audits are now being completed by HR which will support the PIC in identifying gaps in training in a timely manner 2.At supervision the PIC will highlight to staff what training is required 3. All supervisions for Quarter 2 have been completed. 4. The person in charge will ensure quarterly Staff supervision takes place. 5. The supervision documentation will be forwarded to HR by the Person in Charge. 6. Training compliance will be discussed at staff supervision.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. There is now a full time permanent Person In Charge in place. 2. The 2021 scheduled Provider's Audits will ensure that every house in the DC will be audited. 3.The PIC will be responsible to ensure the action plans from the Registered Provider A audit are completed 4. HR has commenced a recruitment campaign for a social care leader to work with the PIC to manage the center. 5.An operational management auditing system will be put in place for the person in charge to complete to ensure consistent review of key quality indicators and compliance	

in DC2 on an ongoing basis.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. The person in charge will ensure All HIQA notifications are submitted to the Chief Inspector within the time-lines as set out in the regulations.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. An Environmental audit of each has been completed by the PIC and this will be reviewed regularly with the Programmer Manager.
2. All concerns with the premises are sent to the technical services department.
3. A new Carpet has been ordered and will be in place within the next two weeks by 4th May 2021.
The radiator will be repaired by 30th May 2021.
The Technical Service Manager will cost the painting of each house. .
A referral has being made to Technical Services to install a press in a more suitable area to hold office files and administration documentation.
works will be completed by 30/12 2021

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The required Medication Management protocol has been completed by the person in charge to guide the staff in administering prescribed medication.
A risk assessment has also being completed.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. Evacuation procedures with a reduced staff capacity at night time have been completed.

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 PIC will carry out a comprehensive review of all the personal plans to reflect the current support arrangements for residents.
This will assess the effectiveness of the plan, and take into account changes in circumstances and new developments.This will be completed by 30th July 2021
2.The person in charge shall ensure that all the personal plans are subject of a review, carried out annually or more frequently if there is a change in needs
All residents have an MDT meeting scheduled for 2021.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Person In Charge has audited all the review dates on the service user's behavior Support Plans and this audit has been forwarded to the Psychology Department.
Dates have been organized for review of the behavioral support plans and will be completed by 30th May 2021.
2. The Positive Behavioural Support Team of the clinical nurse specialist , behaviour specialists and psychologist have completed a shared database to track review dates of behavioural support plans.
3. On this database there is a section on expiry and review dates with an expectation that the team will review any PBSP in advance of the date or earlier if required.
4. The team will meet their line manager on a fortnightly basis in relation to progression and referrals.
5. The Psychology Department has been contacted in review the effectiveness of one

service user’s desensitization plan for phlebotomy. Clarification is expected by 30th May 2021.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The PIC is the Designated Officer and will review all behavioural incidents through the provider's safeguarding procedures and complete the mandatory reporting if an incident is of a safeguarding nature .

2. On site safeguarding training with the safeguarding manager has been organized for the 5th and 7th May 2021. This will ensure all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.
3. Protection will be on the agenda for monthly staff meetings.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2021
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	29/04/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/12/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/12/2021
Regulation 23(1)(b)	The registered provider shall ensure that there	Not Compliant	Orange	29/04/2021

	is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	29/04/2021
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding	Substantially Compliant	Yellow	29/04/2021

	the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/05/2021
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	29/04/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	29/04/2021
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more	Substantially Compliant	Yellow	30/07/2021

	frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/05/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	30/05/2021
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	29/04/2021
Regulation 08(3)	The person in	Not Compliant		29/04/2021

	charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.		Orange	