Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	New Haven
Name of provider:	Praxis Care
Address of centre:	Wexford
Type of inspection:	Short Notice Announced
Date of inspection:	09 October 2020
Centre ID:	OSV-0006653
Fieldwork ID:	MON-0030419

About the designated centre

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

This centre is a single house on a large site in County Wexford. It provides full time residential care to five individuals diagnosed with an intellectual disability, autism, epilepsy, physical disability and mental health issues. The house has nine bedrooms all of which are en-suite. Residents are supported by a staff team comprising of a person in charge and support staff. The centres stated objective is to offer support and care to vulnerable people in the form of practical, social and emotional support which will facilitate the service user’s functioning and their inclusion as citizens in the community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Friday 9 October 2020	10:00hrs to 16:00hrs	Tanya Brady	Lead
Friday 9 October 2020	10:00hrs to 16:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

This centre is home to five individuals, however, on the day of inspection only three residents were present in the centre. As this inspection took place in the middle of the COVID-19 pandemic, inspectors followed national guidance regarding the wearing of personal protective equipment (PPE) and maintaining social distance.

Over the course of the day, inspectors had an opportunity to meet with both staff and residents and observed activities happening throughout the day. Staff were seen to support residents in activities they liked, on a one-to-one basis and residents were also observed taking exercise, such as walks outside of the centre. One resident accompanied by staff went for a drive. Another resident was supported by a staff member to paint garden furniture before it started to rain and both residents were observed tidying up and interactions were viewed as supportive and respectful.

Staff were aware when residents required additional communications supports and explained this to the inspectors to support them in their engagement with residents.

Capacity and capability

This centre had been inspected in February 2020 and had been found to have good levels of compliance with the regulations. However, following receipt of solicited information of concern pertaining to this centre, which was submitted to the Chief Inspector of Social Services by the provider, this risk-based inspection was carried out. There had been a change in management personnel in the centre since the previous inspection and this inspection found that there was increased monitoring and support by senior management in place at the time of this inspection. The purpose of this inspection was to review the provider's governance and management arrangements to ensure a good quality of care and support was provided to residents. This centre was originally registered as 'Oldcourt', however, it became very clear on this inspection that the centre was actually called and known as 'New Haven'. The provider was therefore requested to formally register the centre under its actual name.

Prior to this inspection the provider had been required to submit a number of assurances to the Chief Inspector of Social Services regarding the arrangements in place to ensure residents were safe and provided with opportunities to engage in activities of their choosing. These assurances had been required as a result of the submitted information of concern.

On arrival to the centre the inspectors were also made aware of additional

information relating to concerns regarding protection against infection in the centre. The provider was responding to these. Inspectors were informed that the provider was the subject of a complaint to the Health & Safety Authority (HSA) regarding their COVID-19 prevention against infection practices. Some of the information had not been notified to HIQA prior to this inspection, as is required by regulations.

This inspection found that there were a number of areas of non-compliance that required further improvement. These included governance and management, staffing and prevention against infection. However, it was acknowledged that there was a new person in charge in the centre who had worked to implement changes in a short duration (eight weeks) and in difficult circumstances. This person in charge engaged fully with the inspectors in a positive manner on the day of inspection. It was also evident that a number of new systems had been put in place by the new person in charge which were supported by the head of operations. However, these changes were only being implemented or at early stage of implementation at the time of this inspection. Management systems that had been in place previously did not consistently identify issues that were subsequently noted to be non-compliant by the provider, such as the effective supervision of staff and safeguarding reporting procedures.

The person in charge was full-time and this was their only centre, they were supported by a regional manager and a head of operations and the lines of authority and accountability were clear. The person in charge informed inspectors that they had been seconded to this service from another part of the provider's service, due to a number of challenges that had arisen in the centre. This was an attempt to bring about more stability and consistency to the centre as outlined by management. In the designated centre there were also a number of team leaders in place to support the person in charge, however, their roles and functions were less clear and inconsistent at the point of inspection. Overview of support and care was reportedly implemented on a day-to-day basis by the team leaders who were based within the centre. However, inspectors found that further clarity and consistency was required regarding this team leader role. For example, different team leaders reported a differing understanding and completion of their roles in terms of leadership and management, staff supervision and support. Inspectors found gaps in the completion and standard of staff supervision. In reviewing staff meeting minutes, speaking with staff and management and reviewing a number of pieces of solicited information and information presented on this inspection, inspectors determined there was some discontent and challenges in the staff team that required further input from senior management to improve the centres culture.

This centre has been operational for one year and in that time there had been one six-monthly unannounced report on the safety and quality of care and support and an external quality and governance review. However, not all of the reports as required by regulation were in place. The inspectors acknowledge, however, that there was a quality improvement plan in place arising from these audits and the actions were being completed by the person in charge and person participating in

management at the time of inspection.

There was a team of staff providing support and a continuity of care to the residents in the centre, although this was supplemented by a small number of agency staff. The skill-mix of staff varied with some staff possessing qualifications in social care and some staff possessing no formal qualifications. From a review of the staff training records, the inspectors observed that mandatory staff training was provided in areas including safeguarding, medication management, fire safety and manual handling. However, it was noted that staff had not received training in areas that were of specific relevance to the needs of the residents in this centre, such as training in autism or in the communication systems used by the residents. For example, where residents used Lámh (a manual signing system) to communicate the staff had not received training in how to use it. In addition, all of the residents were reported as having autism support needs, but no training in this area had been provided. Staff who spoke with the inspectors demonstrated a sound knowledge of the residents’ needs and preferences and residents were observed to be comfortable in interactions with the staff in their home.

A review of the rota noted that there was also a consistent number of agency staff providing support in the centre. However, it was found that the levels and skill-mix of staffing in place were not always consistent with the assessed needs of the residents. For example, it was apparent that if all five residents had been present on the day of inspection then support for residents would not be sufficient. The person in charge highlighted that this matter was currently under review and staffing levels would be improved to reflect residents' needs. In addition, inspectors were concerned about the level of support at night to ensure resident safety. This concern was highlighted by the absence of a fire evacuation with the minimal compliment of staff on duty. The person in charge highlighted this would be rectified immediately.

On discussing the area of complaints with the person in charge it was cited as unusual that there were no recorded complaints. The minutes of meetings and documentation reviewed on this inspection cited complaints, however, there were no complaints noted in the provider's complaint logs with only two compliments shown to inspectors.

The inspectors reviewed contracts of care for residents and noted they contained all the information required by the regulations. This included charges and additional charges which residents were responsible for in relation to their day-to-day care and support, with residents having bills and transport agreements as part of their contract of care. Each resident also had a licence agreement in place.

Regulation 15: Staffing

There was a consistent level of staffing providing support and a continuity of care to the residents in the centre, supplemented by a small number of agency

staff. However, the levels of staffing in place were not consistent with the assessed needs of the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider and person in charge had ensured that staff had received the mandatory training, including more recent training regarding infection prevention and control. However, resident-specific training had not been provided, such as Lámh training and autism awareness, which were of specific importance to providing appropriate training to the staff team.

In addition, the team had not been in receipt of formal supervision in line with the provider's policy although the new person in charge was working to ensure all staff were scheduled or had recently been met with.

Judgment: Not compliant

Regulation 23: Governance and management

Oversight and management of this centre required further review from the registered provider. While there were lines of authority and accountability in place, these had changed substantially since the centre had been registered and the effectiveness of this structure required improvement. It was unclear how effective the role of the team leader structure was in supporting the person in charge, supervising and leading the team and monitoring the quality and standard of care. While a new person in charge had been in the centre for eight weeks there were a number of systems and cultural changes required from a governance perspective.

The provider's governance and management arrangements had therefore not ensured that a good quality of care and support had been consistently provided in the centre. In addition, the annual report required by regulation to review the quality and safety of care and support had not been completed.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

All residents had contracts of care, as required by regulation, these outlined all charges that may be in place for the provision of services. Residents also had licence

agreements in place.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider and person in charge had not ensured that all notifications of incidents had been submitted.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were no complaints in the complaint's log, however, complaints were evident through documentation reviewed and discussions with staff. Improvement was required in this area to ensure this was fully understood and implemented so residents who did not communicate verbally had a voice to express their complaints.

Judgment: Not compliant

Quality and safety

The residents living in this centre appeared to be happy and were well cared for. Regulatory improvements were required in the areas of prevention against infection and fire safety. Furthermore, there were areas noted during this inspection where improvements were required to the premises, risk management and safeguarding systems, processes and practices in the centre, to ensure that the service was safe and meeting the needs of the residents.

Prior to this inspection, information had been provided to the inspectors, regarding concerns that individual social care needs of residents were inconsistently supported and facilitated. From viewing residents' files and observation on the day, it was clear that changes had been implemented recently and residents were engaged in activities on the day of inspection. However, as outlined in the section above there was not always a sufficient number of staff present in the centre to support individuals to partake in activities of their choice. The inspectors saw, however, that the residents were being supported to maintain links with their families and friends. At the time of this inspection, access to the community was restricted for residents due to the current COVID-19 pandemic. However, residents were supported to go

for walks in the local vicinity and scenic drives by the sea.

Systems were found in place to ensure the healthcare needs of the residents were being provided for. Regular access to GP services was ongoing and access to a range of other health and social care professionals, in addition to alternative health practitioners if this was resident choice, was provided for as required. Hospital appointments were facilitated and care plans were in place to support residents in achieving their best possible health.

Residents were also supported with their mental health and, where required, had access to psychiatry and behavioural support. Residents also had positive behavioural supports plan in place and it was also observed that staff had training in positive behavioural support techniques. This meant that they had the skills required to support residents in a professional and calm manner if or when required. The inspectors noted that there were a significant number of restrictive practices in place in the centre. However, where some restrictions were in place for individual residents such as limited access to parts of the centre and valve locks on sinks limiting access to water, the impact on other residents had not been fully assessed. This required further review by management. In addition, there appeared to be some absence in the formal recording of all behavioural incidents and application/adherence of behavioural support planning. The new person in charge was found to be working on addressing this issue at the time of this inspection.

Some minor maintenance improvements were required in terms of finishing, painting and gutters. A cistern lid was missing in one resident's en-suite bedroom and this room had a very bare environment. While it was explained to inspectors by staff that some residents' behaviours dictated their environment, the inspectors found that in some parts of the premises (including residents' bedrooms) that an increased effort could be made to provide a more comfortable and homely environment in accordance with residents' assessed support needs.

Systems were in place to identify and mitigate risk in the centre, however, inspectors noted that some risks in the centre were not appropriately managed. For example, risks associated with fire safety. Overloading of sockets was an identified risk, but inspectors found a resident's bedroom had multiple overloaded extension cables and double adapters which were hot to touch and posed a risk of fire. Inspectors required this matter be immediately addressed by the person in charge. While this was a risk that was identified in the centre's risk register it had not been managed in line with the control measures or picked up by any of the daily or weekly supervision or monitoring systems by either staff or management prior to this announced inspection.

Where required, each resident had a number of individual risk assessments on file, so as to promote their overall safety and wellbeing and these had recently been reviewed. However, some improvements were required in the overall assessment of risks as it was observed that the level of risk rating did not accurately reflect either the risk itself or the potential likelihood and impact of the risk and the associated control measures in place. For example, resident aggression and violence was risk

rated as a very high risk, but this was not reflected in inspectors observations, discussions with staff and management and documentation review of this service. Therefore, the risk management documentation did not correspond with the risk management practice.

The registered provider and person in charge had ensured that on the day of inspection some control measures were in place to protect against and minimise the risk of infection of COVID-19 to residents and staff working in the centre. When meeting with inspectors at the commencement of this inspection, the registered provider disclosed that a complaint had been made about this centre to the Health and Safety Authority regarding infection prevention and as a result a number of changes had been recently implemented. This included different entry and exit routes for staff to ensure they were closer to a sanitising station. While, the premises were observed to be clean, inspectors had some concerns regarding prevention against infection. Cleaning mops were viewed to be separated and colour coded, however, on the day of inspection mops were viewed on the ground outside after being washed. There was insufficient access to hand-washing facilities and hand sanitiser observed on inspection for a centre of this size. This was also compounded given the valves that prevented access to water as outlined as a restrictive practice prevented hand-washing in sinks. For example, the inspector used the downstairs bathroom that was used by residents daily and the water was switched off preventing the washing of hands. Given the COVID-19 pandemic this matter required further review.

All staff had adequate access to a range of personal protective equipment (PPE) and were observed to wear these in accordance with national guidance. The infection control policy had been updated to include a guidance document to prevent/manage an outbreak of COVID-19.

Fire safety systems were in place in the designated centre including a fire alarm system, emergency lighting, fire doors and fire extinguishers. Such equipment was being serviced at the required time frames. Residents had personal evacuation plans in place which outlined the supports to be provided to residents to assist them in evacuating the centre. Fire evacuation drills were occurring, however, they had not been completed nor simulated with the lowest levels of staff that were present and therefore did not give an accurate assurance that the premises could be safely evacuated at all times. As an example, during the night shift with the least amount of staff.

There were appropriate procedures in place to ensure that each resident living in the centre was protected from all forms of abuse. Areas of vulnerability had been identified and inspectors saw evidence that reasonable and proportionate measures were taken to ensure the safety of residents where required. Throughout the inspection residents were observed to be comfortable and relaxed in the presence of staff. However, where safeguarding plans were in place inspectors noted that these had not been reviewed and updated as per the provider's policy and timelines. Furthermore the system of reporting had recently been reviewed by the provider following the departure of the previous person in charge. The new person in charge highlighted that cultural improvements were still required in the centre in the

understanding, reporting and recording of risks, incidents and safeguarding incidents.

Regulation 13: General welfare and development

While not all residents were met as part of this inspection (as some were visiting family) the care and support regarding residents' general welfare and development was found to be of a good standard. In addition, two compliments from families also articulated this regarding this centre.

Judgment: Compliant

Regulation 17: Premises

Some minor maintenance improvements were required in terms of finishing, painting and gutters. A cistern lid was missing in one resident's en-suite bedroom and this room had a very bare environment. While it was explained to inspectors by staff that some residents behaviours dictated their environments, the inspectors found that in some parts of the premises (including residents' bedrooms) that an increased effort could be made to provide a more comfortable and homely environment in accordance with residents' assessed support needs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place to manage risks in the centre; however, some aspects such as fire safety and behavioural management, required improvement. In addition, the risk, impact and risk rating of some risks were disproportionate to the actual risk and required review. Control measures were not found to be implemented.

Judgment: Not compliant

Regulation 27: Protection against infection

Prevention against infection practices and review needs to improve in this centre. There was inadequate hand-washing and hand sanitation available. Cleaning

equipment was not appropriately and hygienically stored.

Judgment: Not compliant

Regulation 28: Fire precautions

While fire safety systems were in place in the designated centre including a fire alarm system, emergency lighting, fire doors and fire extinguishers, there were concerns regarding fire safety. A fire risk was found by inspectors on this inspection (overloaded sockets) and fire evacuation drills did not give the adequate level of assurance required to ensure the centre could be safely evacuated. Therefore, there was a disconnect between documentation and practice.

Judgment: Not compliant

Regulation 6: Health care

Systems were in place to ensure the healthcare needs of the residents were provided for and access to GP services (and other health and social care professionals), as required, formed part of the service provided.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors noted that there were a significant number of restrictive practices in place in the centre, however, where some restrictions were in place for individual residents, such as limited access to parts of the centre and valve locks on sinks limiting access to water, the impact on other residents had not been fully assessed. This required further review by management. In addition, there appeared to be some absence in the formal recording of all behavioural incidents and application/adherence of behavioural support planning. The new person in charge was found to be working on addressing this issue at the time of this inspection.

Judgment: Substantially compliant

Regulation 8: Protection

Arrangements were in place to ensure residents were safeguarded from abuse. Staff were found to have up-to-date knowledge on how to protect residents. All staff had received up-to-date training in safeguarding. However, where safeguarding plans were in place for residents they were not reviewed in line with the provider's policy and timelines.
Judgment: Substantially 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for New Haven OSV-0006653

Inspection ID: MON-0030419

Date of inspection: 09/10/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Registered Provider has reassessed the staffing needs of all residents. Date: 11.12.2020 • The Registered Provider has ensured the Statement of Purpose has been updated to reflect this level of assessed need. Date: 11.12.2020 • The PIC has ensured the rota allocation includes the relevant level and skill mix of staff to meet the assessed needs of residents. Date 11.12.20	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Registered Provider has ensured that resident specific training in Autism has been provided to the staff team. Date: 25.11.2020 • The Registered Provider has ensured that whilst unable to access Lámh training due to COVID 19, all staff have been trained in the Lámh signs that the resident uses, enabling all staff to communicate appropriately with the resident. Date 25.11.2020 • The PIC has ensured that all staff receive formal supervision in line with the Policy. Date: 06.12.2020.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The Registered Provider has reviewed the oversight and management of the centre and put the following measures in place:
o New PIC has been appointed permanently to the centre. Date: 13.10.2020
o PPIM is assigned to the centre and available to support the centre four days per week, to be reviewed in 3 months. Date: 01.12.2020
o HR business partner will be in the service one day per month to support all staff, to be reviewed in 3 months. Date: 01.12.2020
o Regional Director will have regular contact with the service with a minimum of one visit to the centre per month, to be reviewed in 3 months. Date: 01.12.2020
o Management oversight extends outside of the 9-5 hours, Monday to Friday - the PIC/PPIM conducts at a minimum four unannounced visits each month to the centre, to be reviewed in 3 months. Date: 01.12.2020
o Monthly management meetings are held to review the Quality Improvement Plan and any issues that arise in the service. Date: 01.12.2020
o The role of Team Leaders in this service has been reviewed and changes have been made to local personnel. TL meeting's are held monthly as well as monthly supervision and onsite support from HR to ensure the effectiveness of the staff in these roles to support the PIC and provide effective day to day oversight and support of the staff team. Date: 01.12.2020
o Annual Review has been completed to ensure the quality and safety of the care provided by the centre. Date: 15.12.2020

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Registered Provider has submitted notifications retrosepctivley. Date: 14.10.2020
• The Registered Provider will ensure that the notification of incidents in the centre are submitted to the regulator. Date 14.10.2020

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

• The Registered Provider has reviewed the complaints procedure in the centre. The PIC will review and update residents individual plans to include nonverbal gestures and behaviors that would indicate that a resident is happy or unhappy with the care and support being provided to them. Date: 18.12.2020
• The Registered Provider has ensured the complaints procedure which outlines who they can contact if they are unhappy or want to make any recommendations about the centre has been sent to residents next of kin. Date: 18.12.2020
• The PIC will review daily notes to ensure oversight of detail and any possible complaints are documented and responded to in line with policy. Date 18.12.2020
• The PIC will ensure Complaints are a standing agenda item on Service user weekly meetings and staff team meetings. Date 18.12.2020

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Registered Provider has ensured that the minor works to the finishing of the centre have been completed. Date 30.11.2020
• The Registered Provider will ensure that the home is made more homely in line with service users wishes and needs for their home environment and bedroom. Date: 31.01.2020
• The PIC will ensure that residents individual plans reflect their personal wishes and preferences around their environment. Date 31.12.2020

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Registered Provider has ensured the review of the risk ratings in the centre has been completed and they are proportionate with the actual risks in the centre. Date: 19.10.2020
• The Registered Provider has ensured that all control measures that are outlined in the risk register and risk assessments and management plans are reflective of what is required and being implemented in the centre. Date: 19.10.2020
• The PIC has shared all updated Risk Assessment and Management Plans have been shared with staff and also discussed at staff meeting. Date: 30.01.2021

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The Registered Provider has reviewed hand hygiene in the centre and there are now electronic hand sanitizers in the centre where hand washing is impacted by a restrictive practice. Date: 23.10.2020
• The Registered Provider has ensured that there is a full review of all restrictive practices in the centre and that any impact on others is assessed and clearly documented. Date: 18.12.2020
• The PIC has updated the Restrictive Practice regarding access to water in the communal bathroom to ensure appropriate handwashing facilities are available when required. Date: 30.12.2020
• The Registered Provider has ensure that cleaning equipment storage is done so hygienically, with a mops procedure now in place, hooks have been installed on the wall for mops to dry and the utility room was refurbished. Date: 16.10.2020

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The Registered Provider has ensured that there is a nightly check of plugs and the plugs are on an extension lead, whereby each plug can be switched off individually. Date: 09.10.2020
• The Registered Provider reviewed the ability to safely evacuate all residents from the building. The following was completed
o Minimum staffing level evacuation where all residents safely evacuated. Date: 14.10.2020
o Review of evacuation with local authority noting it could take approx. 20-30 mins to respond to a fire at the property. Date: 05.11.2020
o Review of Fire Procedure and how to reduce likelihood of fire in the property with the Health and Safety Team. Date: 06.11.2020
o Gas cooker was changed to electric. Date: 06.12.2020
o Two Fire doors of residents who are risk assessed as potentially not evacuating to be changed from 30 minute fire doors to one hour fire doors. Date: 15.01.2021
o Fire evacuation procedure updated based on learning from drills. All staff retrained in updated fire procedure. Date:30.11.2020
o Night time staffing arrangement reviewed to ensure response to emergencies is timely. Date: 04.01.2021
• The Registered Provider has ensured that the documentation regarding risk assessment of fire in the risk register has been reviewed and updated and is assured that all actions

that are taken to reduce the likelihood of a fire are in place. Date: 19.10.2020	
Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The Registered Provider has ensured that there is a full review of all restrictive practices in the centre. Date: 18.12.2020
• The PIC has ensured that where a restrictive practice impacts on others that this is assessed and documented clearly. Date: 18.12.2020
• The Registered Provider has ensured that all incidents are recorded and reported within the centre as per policy. Date: 09.10.2020
• The Registered Provider has ensured that residents receive monthly Positive Behavioral Support reviews and support for staff to ensure the full application of all behavioral plans in the centre. Date: 01.12.2020

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Registered Provider will ensure that all safeguarding plans are reviewed in line with Praxis Care’s policy which include timeframes that are outlined within it. Date: 30.12.2020

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	11/12/2020
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.	Not Compliant	Orange	25/11/2020
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	06/12/2020

Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/01/2021
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	01/12/2020
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	15/12/2020
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	Not Compliant	Orange	30/01/2021

	responding to emergencies.			
Regulation 27	The registered provider shall ensure that 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.	Not Compliant	Orange	30/12/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	15/01/2021
Regulation 31(1)(b)	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: an outbreak of any	Not Compliant	Orange	14/10/2020

	notifiable disease as identified and published by the Health Protection Surveillance Centre.			
Regulation 34(2)(c)	The registered provider shall ensure that complainants are assisted to understand the complaints procedure.	Not Compliant	Yellow	18/12/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	18/12/2020
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/12/2020