Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Lakeview House
Name of provider:	Trinity Support and Care Services Limited
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	03 May 2022
Centre ID:	OSV-0008128
Fieldwork ID:	MON-0035223

About the designated centre

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

The centre is a seven day full-time residential community house that according to the centre's statement of purpose, provides a home for three children/young adults both male and female with an intellectual disability, autistic spectrum and acquired brain injury and may also have mental health difficulties and behaviours of concern . The centre will provide staff support based on the assessed needs of the residents and there are two staff available at night time (one sleepover and one waking night). The premises is a single story detached house, on its own grounds, and comprises of a communal kitchen/dining, living room, sunroom and . each resident has an individual bedroom one of which one is en-suite facilities and another has a shower. The centre is located near a town within access to services and amenities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Tuesday 3 May 2022	10:10hrs to 19:10hrs	Karena Butler	Lead
Tuesday 3 May 2022	10:10hrs to 19:10hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

Overall, the inspectors found that while residents' wishes and choices were respected and supported, there were inadequate systems in place for managerial oversight of this centre. Additionally, there was insufficient structure in place for residents daily lives. Improvements were required in relation to individual assessment and personal plans, positive behaviour support, protection, residents rights, general welfare and development, staffing, training and staff development, premises, food and nutrition, records, governance and management, risk management, protection against infection, and fire precautions. These issues are discussed in detail in the next two sections of the report.

This centre was opened in December 2021 and the purpose of this inspection was to assess how the service was operating in compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations), since their registration.

Inspectors had the opportunity to meet with both residents that lived in the centre. While residents were supported to engage in activities of their choosing, it was observed that residents spent a large portion of the day in the centre, with little planned activities or engagements. They did not attend school or any organised educational programmes. While the inspectors acknowledged that not attending education was each resident's individual choice, there was no evidence of educational plans and insufficient evidence of actions or consideration of future planning in these areas.

Both residents chose to sleep on in bed the morning of the inspection. Staff informed an inspector that it was normal for the residents to chose to do that. One resident went out with their support staff for ice-cream and then spent the majority of the rest of their day in their bedroom. The majority of another resident's day was taken up with sleeping and then playing on a games console while listening to music. Later in the day residents did attend a funfair however, to which they told an inspector they enjoyed.

An inspector completed a walk around of the centre and it was found to be clean and adequate to meet the needs of the residents. There were different areas in which residents could have space for privacy such as a sun room, sitting room and another sitting room area within a kitchen. Each resident had their own bedroom, one of which was en-suite.

There were two games consoles in the sitting room and a third games console in the kitchen. There were several televisions for residents use and, a couple of board games and art supplies. Residents chose not to show the inspectors their rooms and this choice was respected.

The centre had a wraparound garden with football goals and a swing set. However, on the day of this inspection the swing set was not operational. There was also an outside games room that contained a punch bag, as one resident had a particular interest in boxing. However, the resident said they had no boxing gloves and needed to buy some. There were no other game or leisure related activities contained in the games room.

Weekly resident meetings were occurring in the centre in order to support residents to make choices and plan their weeks however, none had occurred since 10/04/2022.

Overall, taking into account the level of non compliance found with the regulations on this inspection, the governance and management arrangements were inadequate in ensuring the service delivered to the residents was safe or appropriate to their assessed needs.

The next two sections of this report presents the findings of this inspection in relation to the governance and management of this centre and, how the governance and management arrangements were impacting on the quality and safety of the service being provided.

Capacity and capability

The governance and management arrangements were not effective in ensuring the service was operated in compliance with the regulations or ensuring a quality safe service was delivered to residents. Inspectors found the centre was not adequately staffed with consistent permanent staff and, there was an over reliance on agency and/or relief staff. Overall, improvements were required in relation to governance and management, the staffing arrangements, staff training and development, and records.

There was a clearly defined management structure in place which included a suitably qualified person in charge who was employed on a full-time basis and they were supported by three team leaders who were due to work the sleepover shifts each day. The person in charge was not on duty the day of the inspection therefore, the inspection was facilitated in part by a team leader who seemed to know the residents well. They could answer the majority of the queries put to them from the inspectors. The remainder of the inspection was facilitated by a team leader from another centre that was filling in for a staff absence. This team leader was known to the residents however, they were not fully familiar with the centre's systems or the assessed needs of the residents.

While it was demonstrated the provider had systems in place to meet aspects of Regulation 23, in terms of carrying a six-monthly provider led audit, the oversight arrangements in the centre were ineffective due to the number of regulatory non-compliance's and substantial-compliance's found on this inspection. For example,

out of 19 regulations reviewed, 14 required action. While the inspectors found there was a suite of eight different audits due to be conducted regularly in the centre, from records viewed only three were completed to date. Audits completed related to fire safety, governance and documentation, and a medication audit. However, actions arising from audits completed could not be verified.

Staff spoken with told inspectors that they felt supported in their role and were able to raise issues or concerns, where necessary, to the person in charge or other senior managers. However, from a review of staff supervision records not all permanent staff had received formal supervision and, a review of staff meeting minutes demonstrated that they had occurred twice since the opening of the centre in December 2021.

On the day of inspection the centre did not have its full compliment of permanent staff. Recruitment had occurred and inspectors were informed by a team leader that all recruited positions were in pre-employment checks. Rosters in place demonstrated that required shift patterns were occurring. However, due to the centre not having the required amount of permanent staff, there was a heavy reliance on relief staff and agency staff, not all of which were known to the residents.

Additionally, as per the centre's statement of purpose, a team leader was due to undertake the sleepover shift each day however, an inspector counted 12 occasions were this was not the case. Not all agency staff that covered shifts received a formal induction other than to self-read resident files. Staff personal files were not reviewed on this inspection due to no access.

On reviewing the staff training records it was difficult to ascertain if all staff had received their mandatory training in order to enable them to safely perform their roles and responsibilities. For example, inspectors could not verify if all staff had received training in fire safety, trainings related to infection, prevention and control, and management of behaviour that was challenging, including de-escalation and intervention techniques. And, while some formal supervision was being provided, it was not evident that all staff were receiving supervision every six weeks in line with the organisational policy.

From a review of other records within the centre, improvements were required in a number of areas. These included, access to required forms such as medication error forms. Residents' files contained duplicate information and in some cases conflicting information. A resident's prescribing document for medication did not give details as to the conditions the medication should be administered and, the provider did not make available to the inspectors the as needed (PRN) medication protocol. In addition, conflicting records in a residents file said they had an allergy and other reports said they did not, leading to confusion for staff and the potential for inappropriate care being provided to this resident. Staff spoken with were still under the impression the resident had the allergy.

On review of a number of incidents that had occurred in the centre, the person in charge had notified the Chief Inspector of Social Services (Chief Inspector) in line

with the regulations when adverse incidents had occurred in the centre. The provider also had suitable arrangements in place for the management of complaints. An inspector reviewed the complaints log and there had been one complaint received which was recorded and appropriately followed up on.

Regulation 14: Persons in charge

The person in charge was employed in a full time basis within the centre. They had the necessary skills, qualifications and experience to fulfill the role.

Judgment: Compliant

Regulation 15: Staffing

The centre did not have a full compliment of permanent staff and as a result there was a heavy reliance on relief staff and agency staff, not all of which were known to the residents. Not all agency staff employed had received a formal induction other than to self-read resident files. Staff personal files were not reviewed on this inspection due to no access. According to the centre's statement of purpose, a team leader was due to cover the sleepover shift each day however, an inspector counted 12 occasions were this was not the case.

Judgment: Not compliant

Regulation 16: Training and staff development

An inspector reviewed staff training records and found it was difficult to ascertain if all staff had received their mandatory training in order for them to carry out their roles effectively. For example, inspectors could not verify if all staff had received training in fire safety training, trainings related to infection, prevention and control, and management of behaviour that is challenging including de-escalation and intervention techniques.

In addition, it was not evident if all staff were receiving formal supervision every six weeks in line with the organisational policy.

Judgment: Not compliant

Regulation 21: Records

From a review of records within the centre, there were improvements required in a number of areas. These included, access to required forms such as medication error forms. Residents' files had duplicate information and in some cases conflicting information. The provider did not make available to the inspectors an in case needed (PRN) protocol which was required in order to administer a particular medication for a resident and the residents prescribing document for the medication did not give details as to under what conditions the medication should be administered. In addition, conflicting records in a residents file said they had an allergy and other reports said they did not, leading to confusion for staff and the potential for inappropriate care being provided to a resident. Some documents were not signed and others not dated. Restrictive practice records were not updated to reflect a change in location of secured items.

Judgment: Substantially compliant

Regulation 23: Governance and management

It was not demonstrated that there were effective oversight arrangements in the centre due to a number of regulatory non-compliance's and substantial-compliance's found on this inspection as 14 out of 19 regulations reviewed required action. While the inspectors found there was a suite of eight different audits due to be conducted regularly, from records viewed only three were completed to date. Audits completed related to fire safety, governance and documentation, and a medication audit. Actions arising from audits completed could not be verified.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre, the person in charge had notified the Chief Inspector in line with the regulations when adverse incidents had occurred in the centre.

Judgment: Compliant

Regulation 34: Complaints procedure

From review of the complaints log the provider had suitable arrangements in place for the management of complaints. There had been one complaint received which was recorded and appropriately followed up on.

Judgment: Compliant

Quality and safety

As previously identified in this report, the governance and management arrangements in place did not adequately support the provision of safe and quality care. Improvements were required in relation to individualised assessment and personal plans, positive behavioural supports, protection, residents' rights, general welfare and development, premises, food and nutrition, risk management, protection against infection, and fire precautions.

Residents were facilitated to choose their daily activities and were supported to receive person centred care. Their communication plans were also clear as to how staff were to communicate with them and support their communication. However, while each resident had their needs assessed, some areas were not completed thoroughly and lacked sufficient detail for example, residents financial management plans.

Additionally, while residents had care plans in place for their assessed needs, there was misguiding information regarding an allergy for one resident which was discussed in section 2 of this report: Capacity and Capability.

Notwithstanding, from a review of healthcare records residents did have timely access to a range of allied health care professionals as required. This included access to a general practitioner (G.P), dentist and the local hospital.

Inspectors reviewed the arrangements in place to support residents' positive behaviour support needs. One resident was being supported to manage their behaviour positively with as required access to a behavioural consultant and, there were positive behaviour support plans in place for this resident. While the other resident also had a positive behaviour support plan completed (by the previous person in charge), the inspector observed it had not been reviewed by a behaviour specialist. The plan contained a post crisis section to direct staff, however, some of the direction had the potential to re-escalate a situation. Additionally, plans were not adequately detailed to guide staff sufficiently for the use of some restrictive practices for residents.

It was also observed that some restrictive practices in place had been assessed as

necessary for a resident's safety and wellbeing. For example, a locked sharps drawer and chemical press. However, an inspector observed that one particular restrictive practice, was not being followed through on which could impact on the safety of the residents in the centre. It was also observed that the person in charge was not trained in safeguarding or children first prior to commencing their role.

While residents' rights to choose their food and activities each day were being promoted, rights with respect to an education were not fully promoted and, there was a lack of structure in their home and daily life. As mentioned previously, residents did not attend school and, the registered provider had not ensured they were adequately supported to access other opportunities for education, training and employment. There was limited evidence of residents being supported to develop life skills to prepare them for adulthood or, to explore relevant training programmes as appropriate to their abilities and interests.

While there was some choice offered to residents on food options to include nutritious food items, this appeared limited and frequently, there was an over reliance on processed convenience foods. One resident in particular did enjoy convenience foods however, due to a particular health issue, they were advised to eat a wider variety of vegetables and red meat. There was no elaboration in their care plan as to how this would be supported and no evidence to suggest it was being undertaken or explored with the resident.

From a walkabout of the centre inspectors found it to be spacious and clean. There were however some areas that required repair work such as some small holes in walls and a loose door handle.

There were risk management arrangements in place, including a risk management policy and procedures. There were individual risk assessments in place for each resident in order to support their safety and wellbeing. However, improvements were required to the oversight of risk management in the centre, as not all incidents (of which there were 48 since January 2022) were signed off by the centre's management team and any follow up, was not recorded.

The provider had systems in place for the prevention and management from healthcare associated infections, including risks associated with COVID-19. Staff had been provided with training in infection prevention and control, and hand washing techniques however, as previously stated a number of staff were overdue refresher courses. Personal protective equipment (PPE) was available in the centre and staff were observed to use it. Inspectors observed some used PPE outside on the ground. There was adequate hand-washing facilities available in the centre however, hand sanitising gels were not available in convenient locations throughout the centre and while this was for the safety of a resident there were no alternatives currently in place for staff to have easy access to these products. There were slight patches of mould around the staff bedroom window seal.

Inspectors observed that there colour coded mops and buckets for use however, the mops were inappropriately stored sitting in the buckets which would not promote adequate drying of the mop heads. While staff were recording fridge and freezer

temperatures daily, there did not appear to be any evidence of follow up in the event when readings were recorded as high.

There were fire safety management systems in place which included emergency lighting and signage, servicing of fire fighting equipment, and fire drills were regularly completed. A resident spoken with was able to talk an inspector through what to do in the event of a fire. However, some improvement was required. For example, one fire door would not close fully by itself and there was some damage and missing areas of a cold smoke seal on two fire doors which would be required in order to resist the passage of fire and smoke in the event of a fire. Fire extinguishers from the hall were being stored in the locked office limiting access to them in the event of a fire. The procedures to be followed in the event of a fire were not displayed in a prominent place.

Regulation 10: Communication

Residents had communication plans which guided staff as to the best way to communicate with each resident and their preferences.

Judgment: Compliant

Regulation 13: General welfare and development

Residents in this centre did not attend school and there was little to no evidence to suggest the registered provider had fully supported the residents to access opportunities for education, training and employment. In addition there was limited evidence of residents being supported to develop life skills and prepare them for adulthood or to explore relevant training programmes as appropriate to their abilities and interests.

Judgment: Not compliant

Regulation 17: Premises

The centre was clean and adequate to meet the needs of the residents. However, some improvements were required such as, the centre's swing set was not operational, there were some minor holes in walls, and the sunroom door handle often came off when used.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

While there was some choice on food options and for the opportunity for nutritious food offered to residents, from speaking to staff and residents there appeared to be an over reliance on processed convenience foods. One resident in particular enjoyed convenience foods however, due to a particular health need they were to be encouraged eat a wider variety of vegetables and red meat. Their care plan did not elaborate as to how this would be undertaken and there was no evidence to suggest it was occurring or being explored with the resident.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

While there were risk management arrangements in place, improvement was required with regard to the oversight of risk management in the centre, as not all incidents of which there were 48 since January 2022 were signed off by the centre's management or follow up recorded.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had systems in place for the management of infection prevention and control (IPC) management. For example, staff had been provided with a number of IPC trainings and PPE was available in the centre and staff were observed to use it. However, improvement was required in some areas such as, used PPE was observed outside on the ground, hand sanitising gels were not available in convenient locations in the centre, there were slight patches of mould around a bedroom window seal, mops were inappropriately stored, and there was no evidence of follow up when fridge/freezer temperatures readings were recorded as high.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place such as, emergency lighting, signage, servicing of firefighting equipment, and fire drills were regularly completed. However, some improvement was required for example, one fire door would not close fully by itself and two fire doors had some damage and missing areas of a cold smoke seal. Fire extinguishers from the hall were being stored in the locked office which would limit access to them in the event of a fire and the procedures to be followed in the event of a fire were not displayed in a prominent place.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had their needs assessed however, some areas were not completed thoroughly with some aspects non-specific and lacked elaboration for example, financial management plan. There were care plans for any assessed needs however, there was misguiding information regarding an allergy for one resident and with little documentary evidence or explanation available to inspectors as to how the diagnoses was changed to state the allergy was no longer applicable.

Judgment: Substantially compliant

Regulation 6: Health care

Healthcare records indicated that residents had timely access to a range of allied health care professionals as required and these included access to general practitioner (G.P), dentist and the local hospital.

Judgment: Compliant

Regulation 7: Positive behavioural support

While residents were supported to manage their behaviour positively, it was observed that one resident's positive behaviour support plan was not reviewed by a behaviour specialist. The post crisis section of the plan contained direction for staff which had the potential to re-escalate a situation. Plans were not specific in relation to restrictive practices to be used for residents in order to guide staff as to how best to support them and it was not evident if one resident had a PRN protocol in order to guide staff as to when they may need medication to support them manage their

behaviour or their anxiety.

Judgment: Substantially compliant

Regulation 8: Protection

An inspector observed that a restrictive practice in place for residents' safety was not being adhered to. One resident with the potential for self-injurious behaviour was observed to spend long periods of the day in their room. The person in charge had not received safeguarding or children first training in order to work in the centre.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' meetings had not consistently occurred weekly in the centre. While residents were facilitated to make decisions about their day to day lives, they weren't fully supported to make informed choices and decisions regarding the long term planning and wider aspects of their care and support.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially 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	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Lakeview House OSV-0008128

Inspection ID: MON-0035223

Date of inspection: 03/05/2022

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: The rota reflects that there is always a team leader on shift as per Statement of Purpose. All staff including agency staff have now received their induction. The compliance of agency staff induction and agency staff supervisions will be reported on the Manager's Monthly Service Report. These Monthly Reports will be signed off by the Managing Director and any concerns will be escalated to the Leadership Team. Transition work has been completed within the Centre, with one resident moving out to on the 20th May 2022. An additional 1 WTE staff have completed their recruitment checks and vetting, this staff commenced in Lakeview House on the 30th May 2022. Based on the assessed needs of the young person within the centre this brings Lakeview House to its full complement of staffing. There is now in place a revised weekly planner in place, as well as a revised key working system which has been implemented as of the 16.05.22. The Manager's Monthly Service Report will reflect the effectiveness of the weekly planner, along with the resident's Monthly Summary Report. The staff team is at its full WTE for the young person residing in the centre.	
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 training matrix has been updated within the Designated Centre to ensure all mandatory training is complete and in date. Outstanding training has been reassigned to staff with a timeframe for completion of 30.06.22. PIC/Manager will reflect this in their Monthly Service Report. Supervision schedule with scheduled future dates for all staff is now in place. PIC/Manager and Director will monitor compliance rates (100%) for training via the Monthly monitoring quality visit, where is less than 100%, and immediate action plan with timescale is implemented and escalated to the organisations risk register.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Medication error forms are in place and the Community Nurse Lead will be completing medication audits on a weekly basis.
Any learning as a result of the audits will be discussed and shared with staff.
All PRN protocols are in place for all PRN medications and health action plans have all been reviewed and up to date. Health action plans form part of the monthly summary reports
Community Nurse Lead has followed up with resident's previous GP, this is now documented in residents' files, and has been handed over to all staff.
All documentation requiring date and signature are now signed and oversight is provided by the PIC.
Resident meeting takes place weekly with Team Leader and PIC. The weekly resident meeting dates are confirmed in the Monthly Service Report.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Audit schedule in place and action plan's reviewed by PIC/Manager. These have been actioned or resolved.– PIC/Manager completes monthly audits as per schedule
The PIC will share their Monthly Service Report with Director.
Director continues to complete monthly an announced and unannounced quality visits. A detailed report is completed with Quality Improvement Plan shared with PIC. to complete quality report.
Six monthly unannounced audits completed in April 2022 – PIC has actioned all substantial and non compliances areas identified.
Restrictive Practice Register is now reviewed as part of the Quality & Governance

Committee. This will also be recorded on the Managers Monthly Service Report.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
PIC has included educational development plans and updated the keyworking system. PIC continues with ongoing meetings with school for resident, exploring educational opportunities. This work is ongoing with identified educational plans now in place.

Weekly planners are in place for resident. This is monitored as part of the Managers Monthly Service Report and Directors Monthly Monitoring visit.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All maintenance issues addressed and actioned. Maintenance log in place and maintenance on site weekly

Additional Fridge/freezer thermometer's have been ordered W/C 16.05.22 and PIC is providing daily oversight of temperatures to ensure they are within range.

Team leaders are reviewing cleaning daily schedule as part of their daily checks. PIC will complete environmental checks weekly as part of their governance oversight. Director to monitor maintenance and infection control within the monthly monitoring visit.

Maintenance /Infection control champion has been identified within the Designated Centre.

As part of Team leader handover, both Team Leaders will do a walk around the centre each day to ensure the premises is clean and where any maintenance issues are identified these are addressed as per level of risk.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
PIC has updated individual support plans on 16.05.22 to reflect the specific needs are reflected and document also in residents daily record file.

As part of the new key working system education session around healthy eating is part of the goals.

Weekly meal planners are in place with oversight of team leaders – resident participates in weekly menu meetings. These revised Menu Planning meetings have commenced as of 10th May 2022.

Educational work has commenced with resident in relation to cooking and understanding of healthy eating.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
New Risk assessment system in place as of 13th May 2022, these have been divided into the following categories:

Individual risk assessment
Environment
Health and safety
Restrictive practice
Systems

Risk register (excel template) reviewed monthly by PIC and Director. There is also a clear process in place where risks are escalated in organisation
PIC has ensured all incidents are signed off and actioned within a timely manner, and where required are escalated in the organisation

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Hand sanitizer in place within the Designated Centre, however individual pocket sanitizer have been ordered for staff, these will include each staff members with individual names attached. Ongoing to be completed by 25.05.2022

Revised cleaning/deep cleaning template system currently being put in place with over sight by TL's and PIC 17.05.2022

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All fire maintenance work has been actioned and completed

At Team Leader handover each morning Team Leaders will complete walk around home to ensure home is clean, all fire doors are closing properly, and any maintenance issues are documented in Maintenance Log Book and reported to Maintenance Team.

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:
New risk assessment system in place (see above)
Personal files currently being completed to be complete by 31.05.22

Community Nurse Lead has updated the health care plans and are completed and up to date. Mental health wellbeing is reflected in health care plan completed on the 17.05.22

PRN protocol in place and signed off by GP on the 05.05.22

Financial care plans: keyworkers completing as part of the new key working system and Key worker's created a document for residents outline their financial entailments

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Behavioral Support Plan completed by Behaviour Specialist with correct date is now in residents file. This has now been archived as Resident 2 has transitioned to new service

PRN protocol in place and has been included in the restrictive practice (new system of recording) a restoration plan is also in place in relation to all restrictive practices for the residents. Restrictive practice risk assessment have been put in place in reference to all restrictive practices.
Restrictive Practice Register is now reviewed as part of the Quality & Governance Committee. This will also be recorded on the Managers Monthly Service Report.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All restrictions have been reviewed and updated on the restrictive practice log, with triangulating evidence to risk assessments.

The training matrix has been updated within the Designated Centre to ensure all mandatory training is complete and in date. Outstanding training has been reassigned to staff with a timeframe for completion of 30.06.22. PIC/Manager will reflect this in their Monthly Service Report. Supervision schedule with scheduled future dates for all staff is now in place. PIC/Manager and Director will monitor compliance rates (100%) for training via the Monthly monitoring quality visit, where is less than 100%, and immediate action plan with timescale is implemented and escalated to the organisations risk register.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Resident 2 has made a choice to move closer to home, staff supported resident with this transition.

Resident meeting’s are taking place weekly.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(3)(c)	The registered provider shall ensure that, where children are accommodated in the designated centre, each child has opportunities to develop life skills and help preparing for adulthood.	Not Compliant	Orange	30/05/2022
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Not Compliant	Orange	30/06/2022
Regulation 13(4)(c)	The person in charge shall ensure that when children enter residential services their assessment includes appropriate education attainment targets.	Not Compliant	Orange	30/05/2022
Regulation 15(1)	The registered	Not Compliant	Orange	30/05/2022

	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.			
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	30/05/2022
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	30/06/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/05/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound	Substantially Compliant	Yellow	30/06/2022

	construction and kept in a good state of repair externally and internally.			
Regulation 18(2)(b)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Substantially Compliant	Yellow	10/05/2022
Regulation 18(2)(d)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are consistent with each resident's individual dietary needs and preferences.	Substantially Compliant	Yellow	10/05/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	10/05/2022
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	Not Compliant	Orange	30/06/2022

	to residents' needs, consistent and effectively monitored.			
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	30/05/2022
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.	Substantially Compliant	Yellow	30/05/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/05/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive	Substantially Compliant	Yellow	30/07/2022

	assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/05/2022
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	10/05/2022
Regulation 07(5)(b)	The person in charge shall ensure that, where	Substantially Compliant	Yellow	10/05/2022

	a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	10/05/2022
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	10/05/2022
Regulation 08(8)	The person in charge shall ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.	Not Compliant	Orange	10/05/2022
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where	Substantially Compliant	Yellow	17/05/2022

	necessary, to decisions about his or her care and support.			