Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Radharc Nua
Name of provider:	Health Service Executive
Address of centre:	Wexford
Type of inspection:	Announced
Date of inspection:	23 August 2022
Centre ID:	OSV-0002633
Fieldwork ID:	MON-0028719

About the designated centre

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

Radharc Nua is a designated centre located in a rural area in Co.Wexford. The centre provides long-term residential care to five adult residents, with intellectual disability, dual diagnosis and significant high support physical and behavioural support needs. Residents living in the centre require full-time nursing care. The staff team consists of nursing staff and support workers. The residents attend day-services attached to the organisation and also have in-house individualised activities. The centre comprises of a large two-story house located in rural location. It has five single bedrooms with two living rooms, a kitchen, dining room, sensory room, five bedrooms, adapted bathrooms and a large accessible garden.

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 (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 23 August 2022	08:30hrs to 18:00hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The overall findings of this inspection indicated that residents were supported in line with their specific assessed needs. Residents appeared calm and content on the day of inspection. This announced inspection was carried out following the provider's application to renew the registration of the centre. The inspector had the opportunity to meet with all five residents that lived in this centre. To gather an impression of what it was like to live here, the inspector spent some time with residents, observed some care practices, spoke with staff and reviewed relevant documentation. The provider and person in charge were committed to providing a service which met each resident's needs. Improvements were required across a number of regulations to ensure the quality of care was optimised for each person living here. There were ongoing identified compatibility issues between residents which at times impacted the lived experience of residents within the centre.

Residents in this centre had lived here for a number of years. The residents used means such as gestures, body language, facial expressions, vocalisations and adapted sign language to communicate their immediate needs. The residents personal space and at times, need for low arousal environment, was respected throughout the inspection process.

The inspection took place during the COVID-19 pandemic. As such, the inspector followed public health guidelines and the use of personal protective equipment (PPE) was implemented as required.

On arrival at the centre the inspector was greeted by the person in charge. A resident was sitting in the foyer of the building. They were holding a preferred object. They smiled when they were introduced to the inspector. The person in charge discussed this resident's plans for the day which included going to a specific preferred sports area. During this time the resident seemed happy and excited and would use loud vocalisations to express this.

The inspector was brought to the dining area to meet the other residents. This area was located at the end of a corridor. The corridor had a door which could only be accessed by using a keypad lock. Also located along this corridor was a sensory room, kitchen, utility room and conservatory. The utility room and kitchen could only be accessed by the key pad lock. There was a hatch between the kitchen and dining area which had a metal shutter in place. This shutter was partially opened at this time. In addition to the restrictions in place there were also signs on display that stated that only four residents were permitted to the dining area at any time.

One resident was present in the sensory room and was seen to move freely between this area and the dining area. This resident also took the person in charge by the hand and led them to the door of the kitchen to indicate that they wanted access to this area. When the resident used this method to communicate this need it was immediately responded too and the resident was brought into the kitchen area.

This resident was waiting for their breakfast and staff were observed to reassure the resident that it was being prepared. When the resident's breakfast was ready they were given this meal. The resident initially sat at the table but then chose to leave this area and eat their meal in the sensory room. This choice was respected by staff.

Another resident was seated at the dining room table. They frequently smiled when spoken too. The used adapted sign language and used this method of communication to tell the inspector that they enjoyed music. They pointed to a shed that was located in the garden that was a designated space for this resident to listen to their music. Music was also playing in the background in the dining area. They were verbally prompted to tidy up after their meal and the resident readily responded to the instruction to do this.

Another resident was relaxing in the conservatory as they had finished their meal. Staff were seen to check in on this resident throughout the observation period. This resident used specific hand and arm movements and was observed to be immersed in this routine. They appeared very comfortable and calm. The final resident in the home was brought to the dining area and was observed to stand at the hatch and wait for their breakfast.

Following the time spent with residents the inspector completed a walk around of the premises. The centre was a large dormer bungalow situated in a rural area. The house was large and overall comfortable, with communal living and dining areas and individual bedrooms for residents. The sensory area of the home had recently been renovated, there was sensory equipment present such as lighting system, bubble tubes, mirrors and a sensory wall. A resident was observed to be enjoying this space. All residents had their own bedrooms which were personalised and had space to store their personal belongings. However, the presence of the metal shutter located at the kitchen hatch was not conducive to a homely environment. In addition to this, the premises was in need of some maintenance with some outstanding paintwork required and noted around the centre.

The residents' families and one keyworker completed a questionnaire in advance of the inspection to reflect their views in relation to care and support in the centre. Resident's families were complimentary of the service being provided and made comments on the residents' newly decorated bedrooms, activities and staff.

While incidents of peer to peer safeguarding incidents were minimal, it did not appear that all the residents were compatible living together at all times. Behaviour support plans in place for a number of residents identified the need for a low arousal environment. In order to achieve this restrictions were put in place. Some restrictions in place impacted on residents' choice and control in their daily lives. There were a high number of restrictive practices in place, such as locked doors, limited access to some areas of the home, high fences and locked gates to segregate parts of the garden. It had been identified by the provider that restrictions in place for identified risks were at times impacting the lived experience for some residents. This issue had been identified in previous inspections and remained an ongoing area of concern.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. Some improvements were required to ensure that the service provided was safe at all times and to promote higher levels of compliance with the regulations. This was observed in areas such as; risk, positive behavioural support, fire safety, residents rights and infection prevention control.

Capacity and capability

Overall, the inspector found that the centre was well managed with good systems for oversight and accountability. The provider had a range of systems for quality assurance. There was clear roles and responsibilities with relevant reporting structures in place. However, improvements were required to ensure sufficient oversight and quality improvement measures were in place at all times that continuously strived to improve service delivery and to ensure that the living environment was the least restrictive environment for all residents within the home.

Overall appropriate staffing levels were in place. There were some vacancies on the day of inspection that the provider was actively recruiting for. The residents' needs indicated that continuity of care was imperative to ensure they were supported appropriately. Residents had specific communication needs that required staff to be familiar with. In addition to this, residents had detailed behaviour support plans which required implementation on a regular basis. In order to achieve best practice in these area continuity of staff was essential. Due to staff vacancies, this was not always achieved and a number of agency staff were utilised to ensure staffing levels were in place.

There was a range of training that was deemed mandatory by the organisation which included, fire safety training, safeguarding, management of behaviours that challenge, manual handling and a suite of infection prevention and control training. All permanent staff had completed this training. However, some training in line with residents' assessed needs had not been completed by the multi-task workers. This arrangement required review to ensure that staff had the most up-to-date knowledge and skills to support residents appropriately.

There was a full-time person in charge and a clear management structure and evidence that the service provided was regularly audited and reviewed. This included an annual review of the care and support and a six monthly unannounced inspection. These audits and reviews for the most part were identifying areas of improvement, for example the premises issues identified on the day of inspection had been highlighted in audit reports. Some issues were identified on the day of inspection required further review and oversight to ensure levels of compliance with the regulations as detailed in other sections of this report.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application to renew the registration of the centre. As part of this renewal the provider had requested to increase the number of beds in the centre from a five bed centre to a six bed centre. This request was under review at the time of this report. For the most part, the required information for the renewal of registration had been submitted as required.

Judgment: Compliant

Regulation 15: Staffing

There was an actual and planned roster in place and for the most part this was well maintained. The staff rota in place which was reflective of the staff on duty. The staff team consisted of nursing staff and multi-task workers

There were a number of staff vacancies on the day of inspection. The needs of the residents indicate that a high level of support was needed for the residents within this home. In order to achieve this ratio and fill vacancies the provider utilised staff from a relief panel and also agency staff. From a review of a sample of rosters, 10 different agency staff were used within a three week period. The use of this level of agency staffing compromised the continuity of care for residents. For the most part agency staff were on duty with regular staff team which mitigated some of the risks of having unfamiliar staff present. The provider had identified this as an area of improvement and discussed the recruitment drive that was currently under way.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a training matrix in place that was utilised to ensure all staff were receiving relevant training. Mandatory training was completed and up-to-date in areas such as safeguarding, IPC measures, managing behaviour that was challenging and fire safety. This was not a comprehensive list and other training had been completed by staff to ensure their skill set was developed and maintained. Recently the organisation had rolled out two new mandatory trainings in consent and cyber security and staff were to complete this training in the coming weeks.

However multi-task workers were not required to complete training in safe

administration of medication, epilepsy and feeding eating and drinking swallowing. Residents living in this centre had specific assessed needs in relation to these areas. Although there were nurses present at each shift, at times, a nurse would be required to go to out in the community with a specific resident due to an assessed needs. This would leave the other four residents with multi-task workers. This arrangement required review to ensure staff present had the appropriate training to meet all residents needs.

Staff supervision systems were effectively implemented with the emphasis on residents' care and support. The person in charge had supervision schedule in place to ensure all staff were receipt of supervision in line with the organisations policy.

Judgment: Not compliant

Regulation 22: Insurance

The centre had up-to-date insurance in the event of an accident or incident occuring.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found that the centre was well managed with good systems for oversight and accountability evident which supported the residents' assessed needs. There was a defined governance structure in place with lines of accountability. There was a full-time person in charge.

There were a range of provider led audits and local audits in place that continually monitored the quality of care being delivered. The registered provider had completed the annual review and unannounced provider visits in line with the requirements of regulations. The person in charge and other members of the management team had completed audits in health and safety, safeguarding and incidents and accidents. Some areas of improvement identified on inspection were identified by the provider in the areas of premises maintenance and infection prevention and control measures.

However, issues identified in the report such as elements of risk management, consistent staffing, staff training needs, review of restrictive practices and residents rights demonstrates that improved oversight and relevant actions were required to ensure the care being provided was consistently monitored and strived for quality improvement. Each of these areas are discussed in further detail within this report.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had submitted an up-to-date statement of purpose that described the service that was being delivered to residents. Some minor amendments were required and this was discussed on the day of inspection. An updated statement of purpose was submitted the following day.

Judgment: Compliant

Quality and safety

On the day of inspection the residents appeared content in their home. Each resident had significant needs in relation to managing their own safety. This was discussed in detail with the inspector and also documented in relevant areas of risk assessments, behaviour support plans and other areas of the residents' care plans. Overall from observations, review of relevant documentation and discussions with staff and other members of management, improvements were required to ensure the service provided was in line with the requirements of the regulations. This would ensure that residents safety and lived experience was enhanced

The inspector found that there were systems in place to assess and mitigate risks. There was a centre risk register in place and individualised risk assessments. These were reviewed on a continual basis. However, some issues were identified on the day of inspection required further review including a fire safety risk, and the management of behaviours that challenge, and risk management around ongoing building works on the ground of the centre.

A number of improvements were required in relation to the management of behaviours that challenge. This included improvements in documentation, practice and reviews of restrictive practices. This would ensure that the provider was exploring the resident's rights to live in an environment that adopted the least restrictive approach to care and support.

Due to the levels of restrictions in place residents' rights at times were impacted. This had been identified by the provider and there was a long term plan to review residents' placements in terms of their relevant assessed needs. However, residents' rights remained non-complaint on the day of inspection and aspects of residents lived experience were impacted by the same.

Regulation 13: General welfare and development

This had been a continued area of focus and development for the staff team to ensure residents had access to meaningful activities and meaningful day. Staff meetings had focused on resident goals. Documented discussions were evident were the wishes and preferences of the residents were at the forefront of planning activities.

There had been a noted improvement in this area. Observations and discussions with staff on the day of inspection indicated different activities that had been planned for the residents. One of these activities was an in house sound therapy session. On the day of inspection three residents had opted to partake in this activity. The other two residents were offered alternative activities at this time as it was their preference not to engage in this activity. During this activity the residents appeared very calm and engaged, they were seen to smile at certain times and there was a relaxed atmosphere present.

From documentation review different activities were offered to all residents such as drives, walks on beaches, listening to music, shopping, house work, skills building, swimming, family visits and other activities were noted. Each resident had their own personal goals which were regularly reviewed to ensure they were in the resident's best interests.

Family feedback indicated that residents were afforded good opportunity for recreation and activities.

Judgment: Compliant

Regulation 17: Premises

The designated centre was a detached bungalow style building. There were area that were designated as communal spaces such as the front foyer, the dining area, conservatory area, sitting room and sensory room. Each resident had their own individualised bedroom with family pictures on display. There was ample storage for personal items. Some bedrooms were en suite and there was also access to two main bathrooms. Both main bathrooms had shower and bath facilities. For the most part the home was well maintained and appeared very clean. There were some outstanding maintenance work that needed to be completed internally and externally. The provider had self-identified this and there was evidence the relevant maintenance departments had been contacted in relation to this. In addition to this some furniture in some areas of the home appeared worn and required replacement

As stated previously there was a hatch located between the dining room and the kitchen. A metal shutter was in place and at times this was partially opened or fully

closed. This did not promote a homely environment.

Judgment: Substantially compliant

Regulation 20: Information for residents

The required information as set put in the regulations was present in the resident's guide.

Judgment: Compliant

Regulation 26: Risk management procedures

There were a number of good practices in place in relation to risk management. The risk register was centre-specific and identified both clinical and environment risks and there was evidence that actions were in place to manage risks identified. Risk assessments were regularly reviewed an updated. Individual risk assessments and management plans were undertaken for residents with risk identified such self-harm, choking or falls.

However, on the day of inspection building works was being undertaken in the garden of the premises. There was open brick work, a working digger and building materials on the grass. One resident required the use of this garden on a regular basis and was a fundamental element of their behaviour support plans. The risks posed in relation to the relevant building works had not been appropriately risk assessed until the day of inspection. The works had commenced a week previous to this inspection. This would require ongoing review to ensure appropriate risk management procedures were in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were suitable procedures in place for the prevention and control of infection which were in line with national guidance for the management of COVID-19 in residential care facilities. An up-to-date COVID-19 preparedness and service planning response plan which was in line with the national guidance with centre specific policies and protocols was in place. The staff had completed the relevant up to date training. The centre appeared visibly clean.

However, the condition of some areas of the home did not provide assurances that

effective infection prevention and control measures could be adhered to. For example, there was small patches of mould present in grouting in shower areas, radiators had rust present and kitchen presses had laminate broken or missing. A comprehensive IPC audit had taken place and these areas had been identified as needing improvements. These works remained outstanding on the day of inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were good systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced regularly by a fire specialist. There was evidence of regular fire evacuation drills taking place and up-to-date personal evacuation plans which outlined how to support the resident to safely evacuate in the event of a fire. Staff were completing weekly, monthly, quarterly and six monthly fire safety checks. There was fire equipment in place around the centre and emergency lighting in place. Fire containment measures were in place and the building could be compartmentalised in the event of an emergency.

However, the kitchen door when opened fully became wedged against a sink unit. In order to close this door a staff member would need to physically pull the door away from the unit. This compromised the effectiveness of fire containment in this area.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A sample of positive behaviour plans were reviewed by the inspector. Positive behaviour support plans were devised by a clinical nurse specialist in behaviour. They regularly consulted with staff and reviewed the plans. They had recently devised a quick guide for staff to reference that contained important information in relation to each person's specific plan. A traffic light system was in place do describe each stage of a resident's engagement during incidents of distress and what strategies should be employed accordingly. There was evidence of function based assessments being completed to inform relevant behaviour support plans.

However, on review of behavioural incident reports in relation to the use of PRN (Prescribed as necessary) for chemical restraint it was not clear what therapeutic methods were employed by staff before the administration of the medication. In addition to this, although there was some minimal guidance for the use of chemical restraint in the medicines management system, there was no PRN protocol in place or any reference to it in the behaviour support plans. This posed an additional risk

as it was not stated clearly that it was only to be used in the event of all other strategies failing. The information reviewed by the inspector did not provide assurances that this restrictive practice was being applied in line with the evidence based practices of a least restrictive approach.

As stated previously there was a number of restrictive practices in place. There was a Rights review committee that reviewed the use of the environmental restrictive practices in the centre. There were also a number of risk assessments in place. On the walk around of the premises there were other restrictive practices identified by the inspector which had not been identified as such. For example, there was a switch in the utility room that was used to switch off the water in the shower. On discussion with the provider and person in charge it was evident that this was in place for an identified risk, however, this had not been considered a restrictive practice and to date had not been reviewed as such.

Although a Rights Review Committee was in place and reviewed environmental restrictions, the exploration of reducing some restrictions had not been documented effectively to date.There was limited evidence that reductions in restrictions had been considered or trialled. This element of reviewing restrictions was essential to ensure that a least restrictive approach to care was considered on a regular basis.

Some restrictive practices in place were impacting on the lived experience of residents within the home this has been addressed under Regulation 9.

Judgment: Not compliant

Regulation 8: Protection

There were systems in place to safeguard residents. There was evidence that incidents were appropriately managed, responded to and recorded. Staff spoken to were clear on what to do in the event of a concern and who the designated officer was. Staff received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Residents all had intimate care plans in place.

Judgment: Compliant

Regulation 9: Residents' rights

Residents meeting were held twice monthly and these were used to discuss any ongoing issues with the residents. However, a number of improvements were required in this area to ensure residents' rights were always promoted and considered.

It had been identified by the provider and also in previous inspections reports that there were compatibility issues, in terms of assessed needs, between the cohort of residents. For example in a recent monthly unannounced visit by a member of management dated August 2022, it stated that 'There was a significant amount of restrictive practices in place,however, some are not in place for all residents and may have an impact on residents' rights'. Observations and discussion on the day of inspection noted some restrictive practices that impacted the other residents within the centre, for example all residents toiletries had to be locked away due to the assessed needs of one or two residents.

Residents' choice and control across their day was also impacted due to the compatibility issues. As some residents were assessed to have the need to have a low arousal environment all residents were not permitted in communal areas at the same time. On arrival at the centre one resident was seated in the foyer and the door to the corridor that lead to the kitchen/dining area was locked. This resident could not access this area at this time. Meal times were staggered to ensure only a maximum of four residents were in an area at a time. This impacted on the residents' ability to choose when they wanted their meals and also there access to all parts of the home during this time. The impact of restrictions on all residents needed to be reviewed in detail to ensure that the environment the residents lived in promoted all residents' rights.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Radharc Nua OSV-0002633

Inspection ID: MON-0028719

Date of inspection: 23/08/2022

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider continues to carry out ongoing rolling recruitment campaigns 2 of the vacant lines are being filled by assigned agency staff for 12 months The allocation of staff is risk assessed on a daily basis Robust induction in place Support and supervision provided for all staff including Locum and agency All necessary training is provided to ensure an appropriate skill mix Supernumerary PIC onsite Mon – Friday for support All 9 MTA lines ae filled by consistent permanent staff	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: HSE Land dysphagia training module has been added to the list of mandatory modules for all staff All MTA staff are scheduled to undertake training in the administration of Midazalom and O2 for use in the management of seizures The cANP is undertaking the Train the trainer Epilepsy awareness training course and in turn will be holding education sessions for all staff All nursing staff are scheduled to undertake a new module in refreshing clinical skills, commencing in November	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
PIC is undertaking Quality, Risk and Safety HSE Risk Register Training
Provider scheduled regular site meetings with the contractor on site to ensure risk assessments and actions are completed and adhered to
Staffing as per Regulation 15
Staff training as per regulation 16
A complete review of all restrictive practice documentation was completed to ensure comprehensive overview of all areas is included
The Rights review committee has amended its referral and review procedure to ensure a more robust process is utilized.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Due to the nature of the residents high support needs all maintenance jobs are ongoing.
All furniture is being replaced and updated as required.
A trial is being undertaken with intermittent removal of the use of the hatch with alternative options being explored.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risk management processes being continuously reviewed while works ongoing until completed in Mid-October.

Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: All areas identified as having IPC risks have been escalated to maintenance for repair or replacement.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Kitchen door was repaired.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A comprehensive review of the residents Medication Administration Prescription Administration Record in conjunction with their Behaviour Support Plans and the required documentation guidance is being undertaken by the CNS and the Psychiatrist. All restrictive practices deemed necessary following risk assessment are now approved and documented appropriately on the restrictive practice register. A complete review of all restrictive practice documentation was completed to ensure comprehensive overview of all areas is included The Rights review committee has amended its referral and review procedure to ensure a more robust process is utilized to ensure evidence of any attempts in the reduction or removal of a restriction	
Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
A draft compatibility tool has been developed and circulated to PIC's for review and feedback.
A compatibility review is currently ongoing for all residents across the service to prepare for the next phases of decongregation
Internal work practices have been reviewed in line with risk management and residents rights.

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(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.	Substantially Compliant	Yellow	31/01/2023
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	31/03/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	31/12/2022

	state of repair externally and internally.			
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.	Substantially Compliant	Yellow	31/10/2022
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	01/09/2022
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	Substantially Compliant	Yellow	31/12/2022

	published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/09/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	01/09/2022
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	01/09/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his	Not Compliant	Orange	31/12/2022

	or her daily life.			