Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Name of designated centre:	Camphill Community Carrick on Suir
Name of provider:	Camphill Communities of Ireland
Address of centre:	Tipperary
Type of inspection:	Announced
Date of inspection:	23 and 24 July 2018
Centre ID:	OSV-0003608
Fieldwork ID:	MON-0023231

About the designated centre

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

The service is described as offering long-term residential care to 15 adults, both male and female with intellectual disability, autism sensory and physical support needs who require medium levels of support .The accommodation and support arrangements are varied to meet the different needs of the residents. The centre comprises two residential houses which accommodate four residents each, and seven individual semi-independent supported houses which accommodate individual residents and in some instances a number of short or long term co-workers. There are workshops and horticultural facilities available to all of the residents. Training facilities and day services are available on site and in other locations. The accommodation is homely and comfortable with all of the facilities necessary for the residents currently.

The following information outlines some additional data on this centre.

Current registration end date:	23/11/2018
Number of residents on the date of inspection:	14

How we inspect

To prepare for this inspection the inspector or 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
23 July 2018	09:30hrs to 18:00hrs	Noelene Dowling	Lead
24 July 2018	09:00hrs to 13:30hrs	Noelene Dowling	Lead
23 July 2018	09:30hrs to 18:00hrs	Julie Pryce	Support
24 July 2018	09:00hrs to 13:30hrs	Julie Pryce	Support

Views of people who use the service

Inspectors met and spoke with six of the residents and others allowed observation of some of their routines. Residents showed inspectors their rooms and told of how much they enjoyed their various activities, holidays and work .The said staff supported them when they needed it ,they had a lot of fun and loved planning their trips and weekends. They showed their art work and achievements and said they were happy with their new fire safety arrangements and staff always responded to them when they asked for support with housekeeping or other issues. Some residents also completed questionnaires and these were also very positive regarding their lives in the centre.

Capacity and capability

Inspectors found that the provider's management systems and structures supported residents care, wellbeing and safety.

There were effective systems in place for monitoring of care and evidence of responding to and planning with residents for their future needs and personal preferences.

The management team consisted of the regional manager, person in charge and designated safeguarding officer / deputy manager. All had clear roles and responsibilities which were being carried out effectively. This was to the benefit of the residents and the findings of this report in terms of residents' rights, safety and welfare demonstrate this.

The actions required following the previous inspection had been carried out effectively and in a timely manner. These included structural improvements in fire safety systems which had necessitated a significant financial input.

There were effective and ongoing quality assurance systems. These included robust audits of accidents and incidents, medicines administration systems, and staff training needs. Any actions required following these were seen to be addressed by the person in charge and monitored. For example, medicines errors were reviewed promptly and follow up training and re-assessment of competency was undertaken if necessary. The reporting structure was also robust with documented and responsive reporting arrangements at all levels evident.

The arrangements for oversight in each unit were satisfactory. There were employed staff as house co-ordinators two units and long term co-workers in the semi independent supported units. These arrangements were also under review.

Inspectors were satisfied that the staffing agreements were suitable in terms of skill mix and numbers. Rosters were seen to be thoughtfully planned, based on each

individuals need for support and experienced staff. A number of residents had one-to-one staff supports.

The number of employed staff had been increased which ensured there was better accountability and defined responsibilities. The reduction in the numbers of short term volunteers allowed for more appropriate use of and less onerous responsibilities for these young people, while also maintaining the valuable additional support they provided to the residents. The intake of the volunteers was staggered to avoid unnecessary distress to the residents. There were employed or very experienced trained co-workers in units or easily available at all times.

The specific roles of the volunteers were still under review by the provider nationally. Definitive rules had been implemented however governing their off duty behaviour and accommodation which were adhered to and ensured residents were not subject to any untoward behaviours in their homes.

Recruitment procedures including the recruitment of the short term co-workers were satisfactory with all of the required documents and checks being completed. Supervision of all grades was regular and the content was suitable to the role and responsibilities of the staff. Any staff performance matters which arose were seen to be managed effectively and promptly.

Employed staff had a range of suitable training including social care and all mandatory training had been undertaken. Staff had also received training in additional behaviour supports which was seen to be helpful to the residents. There were regular unannounced visits on behalf of the provider and the annual report compiled was detailed and transparent.

The views of both residents and families were ascertained and reflected positively on the care provided. Inspectors also found that where parents raised concerns these were managed in a spirit of consultation and transparency. In one instance some further details were required to fully demonstrate process and outcome. However, the matters were addressed.

All staff and the managers demonstrated a sound knowledge of practice and their own roles and responsibilities. Staff and managers were seen to be very familiar with the residents' needs and preferences and fully engaged with them.

The statement of purpose, which is a key governance document, was satisfactory and the care provided and admissions were in accordance with the statement. The application for registration had been made on time and satisfactorily.

Registration Regulation 5: Application for registration or renewal of registration

The application for renewal was made as required.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced and full time in post.

Judgment: Compliant

Regulation 15: Staffing

Staff numbers and skill mix was satisfactory and recruitment practices were safe.

Staff numbers were augmented by the use of a number of short and long-term co- workers.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had the training and knowledge required to provide the care needed for residents according to their roles and responsibilities.

Judgment: Compliant

Regulation 21: Records

All of the records and polices required by regulations were maintained.

Judgment: Compliant

Regulation 22: Insurance

Insurance was forwarded with the application and was satisfactory.

Judgment: Compliant

Regulation 23: Governance and management

There were effective and accountable leadership and management arrangements in place.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a publicly available statement of purpose which accurately describes the service being provided.

Judgment: Compliant

Regulation 30: Volunteers

Arrangements for the volunteers are currently suitable and their roles are overseen closely by staff.

These are being revised nationally.

Judgment: Compliant

Regulation 31: Notification of incidents

All of the required notifications had been forwarded to HIQA.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

There were suitable arrangements in place for the absence of the person in charge and these were notified to HIQA.

Judgment: Compliant

Regulation 34: Complaints procedure

Complaints were managed promptly and transparently but some further detail was required in the documentation to clearly demonstrate the the process and outcome.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

All of the required policies were in place.

Judgment: Compliant

Quality and safety

Inspectors found that there was a commitment to the provision of person-centred and safe care for the residents.

Residents had a good quality of life with meaningful activities, work, access to the community and to holidays based on their individual needs and their own expressed preferences. This were supported by access to range of pertinent allied services and assessments including health care, psychology and psychiatry which helped to inform the personal plans for the residents. Easy read versions of their personal plans were used by the residents.

Inspectors found that both residents and families were closely involved in decision making and planning for their lives. Their rights were actively promoted, with a significant level of consultation in their living arrangements and routines. Privacy and dignity was respected with detailed personal care plans available for the more vulnerable residents. Residents were observed to be very comfortable with the staff and enthusiastic about getting on with their day.

Residents had appropriate assessments for support with financial and medicines management, and their level of staff support and individual accommodation was tailored to and appropriate to their individual need. Inspectors observed staff communicating with residents in their preferred manner and staffs were able to use sign language. Their communication was detailed in their personal plans which also detailed how they might react to pain or distress.

Inspectors saw that staff supported the residents themselves to be informed and to

take control of their lives including their health and medicine management with training and information. Dietary needs were known by staff and where necessary up to date speech and language assessments had been undertaken and the recommendations were adhered to. The food was freshly cooked and of good standard. Some residents prepared their own meals in the houses or helped staff to do so.

Resident had good access to the local community and had recently opened a coffee and craft shop in the community.

They were actively involved in their own hobbies such as weaving or art and these were actively encouraged. They went horse riding, swimming, and to local festivals, music events and a number had just returned from a sun holiday with staff. They shopped locally and used public transport as their needs allowed.

The risk management systems were effective, responsive and proportionate to the individuals and the environment.

Some improvements were required in the details of the risk management policy and the risk register. While comprehensive, the register did not provide sufficient details to indicate the strategies taken to manage the risk identified. However, in practice, there were detailed and pertinent risk assessment and management plans for each individual resident including falls risks, unauthorised absence, health care, diet and personal safety. The procedures in place were satisfactory. Residents were also allowed and supported to take appropriate risks.

All incidents were promptly responded to. For example, following a fall the environment was reviewed, clinical assessments undertaken and additional support mechanism such as grab rails, and shower chairs provided. However, a resident's mobility was deteriorating. Inspector observed and the resident said that stairs and bathrooms were becoming problematic. Plans to build a small single house where the resident could live with the support of the staff beside the main houses were at an advanced stage but not yet fully agreed. The resident outlined this to inspectors and had been fully involved in the planning. However, despite the additional safety measures the use of the stairs and bathrooms was becoming more difficult in the interim.

Health and safety systems were in place and frequently reviewed.

All of the required fire safety management equipment including containment doors had been installed as required and all equipment was serviced. Residents participated in regular fire drills at various times. Sleepover staff or co workers were assigned duties each night to respond in the event of a fire.

Overall systems for the protection of vulnerable adults were proactive and responsive. There was evidence that all incidents including past incidents not previously known were reported to the relevant agencies promptly and transparently. The person in charge and designated officer were found to have acted appropriately in response to any incidents which occurred. Safeguarding plans were implemented, where necessary. Actions had also been taken to address issues

of compatibility of residents which had impacted on the wellbeing of others or where residents' needs were not being met in the group environment. Inspectors saw that this was undertaken in a consultative and considered manner, supported by revised clinical assessments. Advocates and social work interventions had been available to achieve the best outcomes for the residents.

The provider was acting as de facto guardian for a resident. Since the last inspection consideration was being given to formalised arrangements in order to provide better oversight and protection for the resident. An external advocate had been sourced to support this and advise on options.

The management team were implementing a revised protocol for decision making regarding the resident's finances and care. No untoward actions were found by inspectors but the system did require a more robust and formal system for oversight to ensure the resident's best interests were being protected. The arrangements for the resident's support/review meetings required review as it was not demonstrated that there was a system in place for overseeing who should represent the resident at these meetings.

Despite this significant anomaly however, there was sufficient evidence from other actions taken by the management team that the protection of the residents was prioritised.

Since the last inspection the living arrangements for children living in, but not residents of the designated centre had been revised with suitable safeguarding plans implemented.

There was clinical guidance for the support of behaviours that challenge. Detailed support plans were implemented and overseen by clinical specialists to promote a reduction in behaviours for the residents. Residents were also seen to be supported to manage and understand their own behaviours. Medicines management systems were safe and medicines were frequently reviewed. One area for improvement was required in the monitoring of the fridge temperatures for medicines which required this.

Regulation 10: Communication

Residents were supported to communicated effectively, their needs were detailed in their personal plans and staff were very familiar with these.

Judgment: Compliant

Regulation 12: Personal possessions

Residents personal possessions were itemised and they were helped to keep them

safe.

Judgment: Compliant

Regulation 17: Premises

While all of the houses were generally suitable for the residents' needs in one case the stairs and bathroom layout impacted on a residents mobility and ability to remain independent in the future. This required review.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Food was nutritious , fresh and varied and the residents dietary needs and preferences were addressed.

Judgment: Compliant

Regulation 20: Information for residents

Residents were provided with easy-read suitable information in relation to the service, their rights, fees and complaints.

Judgment: Compliant

Regulation 26: Risk management procedures

While residents were protected by effective risk management procedures some improvements were needed in the policy to ensure it covered all of the regulatory requirements and in the risk register to detail the actions taken and monitor the outcomes.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Systems for the management of fire were good but additional strategies were required for the use of open fires and candles.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

While medicine management systems were good storage for medicines which required refrigeration was not monitored.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had access to all pertinent assessments, personal plans were implemented and the effectiveness was reviewed in conjunction with the residents.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to have the best possible health.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents had good access to clinical support for their behaviours and mental healt needs and staff were familiar with the supports needed.

Judgment: Compliant

Regulation 8: Protection

While there were robust safeguarding systems implemented and there was evidence of transparency in recognising and reporting any concerns some arrangements regarding how residents' best interests were represented required review. This was an area which required review.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' rights sere actively promoted and their views and preferences for their lives elicited and listened to.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Camphill Community Carrick on Suir OSV-0003608

Inspection ID: MON-0023231

Date of inspection: 23 and 24/07/2018

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 34: Complaints procedure	**Substantially Compliant**

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

1. The PIC will review and amend existing complaints policy to provide guidance on:
   1.a The use of informal complaints resolution processes locally in house/workshop and,
   1.b The investigation process in the formal complaints procedure at Stage 2 in the policy**. To be completed by 31/10/2018**
2. The registered provider will ensure that:
   2.a. Guidelines on use of informal complaints resolution processes (locally in houses/workshops) has been drafted to enable quick local resolution of complaints, to be monitored by the PIC, and to be used to acquire any learning.
   2.b. Guideline on complaints investigation procedure to be inserted into 8:2 of center policy to include
      2.b.1- On receipt of formal complaint the provider to appoint a person to investigate complaint, as well as a person to support the resident to ensure that the complaint is appropriately responded to.
      2.b.2- Set the terms of reference for investigation
      2.b.3- Make an investigation plan detailing the person to be interviewed and the documents to be examined
      2.b.4 -Ensure that residents are supported to communicate their complaints, understand the complaints procedure and their wishes, through the process.
      2.b.5- The investigator will produce a full report and recommendations for the PIC who will sign off on the report and ensure recommendations and learning are acted on.
      2.b.6 The resident who makes the complaint will be asked to indicate their satisfaction with the outcome. **To be completed by 31/10/2018**
3. A new easy read version of policy and procedures, appropriate to the needs of the residents, will be developed. **To be completed by 23/11/2018**
4. All residents and their families will be familiarized with the amended complaints procedure and know who to complain to. Send updated policy to family and address it in Family and Friends day. **To be completed by 30/11/2018**

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

1. Bath lift will be serviced in compliance with manufactured recommendations, in addition visual inspection of bath lift will be carried out and documented monthly. **To be completed by 04/09/2018**
2. Formalize monthly inspection of health and safety, property and maintenance (In addition to the Bi annual external independent health and safety oversight). **completed by 04/09/2018**
3. The provider will notify the HSE (CHO7 and CHO5) of the high priority re health and safety capital; to replace pavement in Castle Street premises**. To be completed by 07/09/2018**
4. A resident with mobility issues who lives in a group house will be supported to transition to a single occupancy in accordance with the resident's goal in the personal plan.
   4.a Initial transition meeting within a case conference. **To be completed by 31/09/2018**
   4.b Application for registration of the new unit will be made on the completion of work on the house. **To be completed by 31/11/2018**.
5. Another resident who has high mobility needs has agreed to move to ground floor accommodation which has a wheel chair accessible bathroom. The accommodation is in a group house which will become available. As soon as step one is completed.
   Plans for a purpose build accommodation for the above resident will continue to be processed**. Agreement to transition to new accommodation was completed on the 04/09/2018.**

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

1. Risk management register to be updated, summarizing details of risk management plan and control measures. **Commencing 01/10/2018, completion 31/10/2018**
2. To develop a National Risk Management Policy, with terms and reference to separate the risk policy from the risk management frame work.
   Set up national working group –to be completed by 31/10/2018
3. To develop a person-centered risk identification document to identify risks listed in regulation 26(c).
   To be completed by-31/10/2018
4. **(a)** Interim risk management policy to reflect regulation 26 to be put in place. **(b)** Risk management procedure will be put to national office
   (a)Interim policy completed 03/09/2019 (b) To be completed by 31/10/2018

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

1. To develop a specific guideline on the safe use of candles and open fires. These will reflect risk assessments and the fire prevention policy already in place.
   To be completed by 31/10/2018
2. **External open Fire (**a) all external open fires will be consulted with H&S officer or PIC for approval to follow **(b)** local guidelines re external open fires.
   (a) Guideline to be completed by 31/10/2018
   (b) Consultation with H&S or PIC began on 30/07/2018

3. **(a)**To develop a guideline document for safe use of candles followed by **(b)** staff training**. (a)To be completed by 31/10/2018 (b) To be completed by 19/11/2018**

4. Existing open fire in a single occupancy self-directed unit will be replaced with an insert stove.
   To be completed by 30/11/2018

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

1. **(a)** A fridge thermometer will be used to ensure medications are stored at their specified temperature. **(b)** Fridge temperature will be recorded daily at 8:00 am
2. **(a) completed on 25/07/2018 (b) to be completed on 30/09/2018**
3. Fridge will be removed to a more secure location.
   Will be completed on 07/09/2018

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

1. The centres stated policy of zero tolerance to abuse will be reiterated to all staff in formal training, through team meetings, supervisions, role modeling, Personal Improvement Plans, as well as by a prompt response to any suspected or reporting of abuse.
   Complete retraining by 15/12/2018
2. Six staff in management have participated in Designated Safeguarding Officer training.
   Completed in February/ 2018
3. A weekly checklist from PIC to RM has been introduced to gather key data on all incidents, accidents and safeguarding reports, to increase corporate oversight.
   Completed 01/03/2018
4. Potential abuse will continue to be cross referenced when screening reported accidents and incidents, and when complaints are received.

On going

5. **(a)**Residents and support staff participate in inclusive training: 'Say No to Abuse'**. (b)** Some residents with additional needs (using sign language, on the autism spectrum disorder with hearing impairments) will receive tailored made training designed to make it accessible to them.
   (a)Inclusive training to be completed by 31/11/208.
   (b)Individualized training- To be completed by 31/10/2018
6. An external committee will be formed to oversee decisions made on behalf of vulnerable residents where Camphill Carrick on Suir is the defacto guardian, this includes a solicitor and a CORU registered social worker and a provider nominee.
   To be completed by 30/09/2018
7. Participants in 'circle of support' and 'oversight committees' for residents will be recruited, vetted and Garda / police cleared as per existing policy for engaging paid staff and volunteers.
   To commence on 05/09/2018 by reviewing present participants of all circles of support.
8. Review all Residents who have been a subject of historic abuse and update their risk assessments and safeguarding plan.
   To be completed by 31/10/2018.
9. **Shared learning in safeguarding:** the service took part in an on-site review by HSE / ACRUX in July / August 2018. This will be used to critique the self-assessment audit of 2017. The service will revise and adopt any best practice learning arising from its local engagement with HSE / ACRUX or from the wider Camphill review by HSE / Acrux**. Completion date yet to be advised by HSE**
10. **Best practice in supporting BTC: (a)** The service will roll out studio 3 training to all personnel. **(b)** The service will upskill one staff member as a trained trainer to oversee practice and to contribute to the BTC programme development and review. **(c)**The service will engage the clinical supports of Studio 3 where initial assessment and ongoing clinical input is required **(a)-Will formally begin in 2019 (b) will be completed by 15/12/2018 (c)Commenced in March 2018.**
11. To introduce an easy read 'key working' template to all residents - A nominated key worker will have a weekly meeting with assigned resident to address area of complaints and dissatisfaction among other headings. This template is currently in use by several residents.
    To be completed by 31/12/2018

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 by
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	**31/12/2018**
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected absence of any resident.	Substantially Compliant	Yellow	**31/10/2018**
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the	Substantially Compliant	Yellow	**31/10/2018**

	risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.			
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Substantially Compliant	Yellow	**31/10/2018**
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Substantially Compliant	Yellow	**31/10/2018**
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	**31/10/2018**
Regulation 28(1)	The registered provider shall ensure that	Substantially Compliant	Yellow	**30/11/2018**

	effective fire safety management systems are in place.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	**30/09/2018**
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	**30/11/2018**
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	***Stage1*-commencing on 05/9/18 Completed on 31/12/2018** ***Stage 2-*Studio 3 training commencing in 2019**