Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

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| Name of designated centre: | Boherduff Services |
| Name of provider: | Brothers of Charity Services Ireland |
| Address of centre: | Tipperary |
| Type of inspection: | Announced |
| Date of inspection: | 29 March 2018 |
| Centre ID: | OSV-0005291 |
| Fieldwork ID: | MON-0020871 |

## About the designated centre

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

Boherduff Services is a five bedroom one–storey detached house. It is open overnight 365 days of the year on a 24 hour basis at weekends and during day holiday periods. The centre provides residential services for four people of mixed gender, for both full time and shared-care arrangements, who have intellectual disability with complex needs who may also have a diagnosis of Autism Spectrum Disorder. The centre has a unique staffing complement matched to the particular needs of the people supported. The staffing team in place consists of a social care leader, social care workers and care assistants. Staff levels are assessed as individual needs change and if required, alternative placement or permanent increases in staff supports are sought. The centre aims to provide a homely environment that is tailored to individual preferences and needs. Residents living in the centre are encouraged to actively participate in the local community and are provided with opportunities to utilise the services within the community. The centre has the full use of a suitable vehicle for the transportation of residents.

**The following information outlines some additional data on this centre.**

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| Current registration end date: | 31/03/2020 |
| Number of residents on the date of inspection: | 4 |

## 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 |
|---|---|---|---|
| 29 March 2018 | 10:00hrs to 19:00hrs | Conor Dennehy | Lead |
| 29 March 2018 | 10:00hrs to 19:00hrs | Noelene Dowling | Support |

## Views of people who use the service

Inspectors met three of the four residents who lived in the centre at the time of this inspection. These residents used a variety of communication methods. As a result inspectors engaged with residents in a number of ways such as observation and conversation. Inspectors also reviewed a pre-inspection questionnaire that one resident, with the assistance of a staff member, had completed.

Residents were observed to be relaxed in the centre and were provided with appropriate support throughout the inspection. One resident who inspectors met, spoke positively about the centre, their living environment and the support that they received from staff.

The designated centre was presented in a homely manner throughout. One resident choose to show inspectors their bedroom which had been personalised to reflect the resident's preferences by items such as photographs and furniture.

Residents appeared comfortable in the presence of staff members present and were observed engaging with them in a positive and warm manner throughout the inspection.

## Capacity and capability

Throughout this inspection inspectors observed and saw evidence that residents were supported to enjoy a safe and quality service as was reflected by a good compliance level across some of the regulations inspected against. The centre was well resources with a responsive work force. However, it was found that governance systems in place required review to ensure the quality and safety of the service provided to residents was consistently monitored and maintained.

This centre was registered until April 2020. In September 2017 the provider submitted an application to change the nature of the service provided to meet the needs of the residents living in the centre on an ongoing basis. Inspectors were satisfied, particularly given the consistent staff team in place and the current configuration of the premises, that this was a suitable arrangement at the time of this inspection. However, this was an area that would require ongoing review in light of the specific needs of the residents living in the centre.

The provider had systems in place to monitor the quality and safety of the service provided including a clear structure and reporting arrangements. This centre had been previously inspected in September 2016 and since then the centre had

reconfigured. Failings identified previously had been addressed by the provider within the timeframes stated. A system of audits was also in place and inspectors saw evidence that issues identified in such audits had been addressed. A suitable person in charge had also been recently appointed by the provider in January 2018.

As part of the management systems in place the provider had carried out annual reviews and unannounced visits at the required intervals. The most recent unannounced visit report by the provider to review the quality and safety of care provided had been carried out in the week before this inspection. However, while some of the findings of the provider's own internal management systems were also evident during this HIQA inspection, they did not identify some important failings which impacted on residents safety and well being. For example, the provider's monitoring systems had not highlighted that one particular form physical intervention required further assessment nor that some fire evacuation procedures required review.

However, the provider had made good arrangements to ensure an effective staff team was in place. There was a consistent and knowledgeable staff team had been put in place in the centre. Staff members spoken to were able to accurately describe the specific needs of the residents and the supports required to provide for these. The details that were contained in residents' personal plans largely corresponded with the information given to inspectors by staff members. Inspectors also observed staff members engaging with residents in a positive, respectful manner and providing appropriate support if required. This provided assurance to inspectors that residents were provided with a safe and quality service.

Having read information relating to residents' specific needs, speaking to staff members and reviewing staff rosters, inspectors were satisfied that there were appropriate numbers of staff provided to meet residents' needs. Rosters also indicated that a continuity of staff was in place which was particularly important given the assessed needs of some residents. Residents present in the centre on the day of the inspection appeared comfortable in the presence of staff and were observed being supported in an appropriate manner. However, some gaps in formal supervision of staff and refresher training were found and this required improvement.

## Regulation 14: Persons in charge

A suitable person in charge had recently been appointed in January 2018. The person in charge had the required management and supervisory experience and was in the process of completing a management qualification which was due to completed in May 2018. The person in charge was responsible for this designated centre only, was in a full time position and had protected time to carry out their duties.

Judgment: Compliant

## Regulation 15: Staffing

There were appropriate numbers of staff with the necessary skill mix to meet the needs of residents living in the centre. The residents were not assessed as requiring nursing care but nursing input was available if required.

Planned and actual rosters were maintained in the centre. From reviewing these rosters and talking to staff members present, inspectors were satisfied that there was a continuity of staffing provided for residents.

A sample of staff files were reviewed and found to contain all of the required information such as evidence of Garda vetting and two written references.

Judgment: Compliant

## Regulation 16: Training and staff development

Arrangements were in place for staff members to receive supervision and inspectors saw some evidence of formal supervision having taken place in the months before this inspection. However when reviewing staff files it was noted there were some gaps in formal supervision for staff during the latter part of 2017. This was confirmed by the person in charge.

Staff were provided with training in a wide range of areas but some staff were overdue refresher training in areas such as manual handling, medicines management and de-escalation and intervention as evidenced by a learning needs analysis carried out in November 2017 and from training records reviewed on the day of inspection.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

A directory of residents was in place which contained all of the required information.

Judgment: Compliant

## Regulation 21: Records

The vast majority of records requested on the day of inspection were provided for. However, inspectors were informed that one resident was referred to a dietitian in May 2017 but a record of this referral was not available in the centre on the day of inspection.

It was also observed that the maintenance of some personal plans required review to ensure ease of retrieval and accuracy. For example, in one resident's personal plan it was noted that there was three copies of the same document while there were also two specific plans in place which were dated differently and had different levels of detail contained within them.

Judgment: Substantially compliant

## Regulation 23: Governance and management

There was a clear governance structure in place with identified lines of accountability and authority. Staff reported to the person in charge who in turn was supported by other persons participating in management.

Annual reviews had been carried out for 2016 and 2017 which included consultation with residents and their representatives.

The provider had ensured that unannounced visits had been carried out in the centre at six monthly intervals. Such visits generated a written report with a corresponding action to address any failings identified. Audits were carried out in areas such as medicines management and health and safety.

However the management systems in place did not identify some of the failings as evidenced by inspectors during this inspection. For example, the provider's monitoring systems had not highlighted that one particular form of physical intervention, which had been in use since 2016, required assessment and approval.

It had also not been identified that the fire evacuation procedures for one resident, which had been reviewed most recently in May 2017 required clarity and further review particularly given that fire doors were not present throughout the designated centre.

Judgment: Not compliant

## Regulation 24: Admissions and contract for the provision of services

Inspectors saw a sample of contracts for the provision of services and noted that they contained all of the required information including the services to be provided. There had been no new admissions to the centre since the previous inspection.

Judgment: Compliant

## Regulation 3: Statement of purpose

A statement of purpose was in place that accurately described the nature of the service provided and contained all of the required information.

The statement of purpose had been most recently reviewed in January 2018.

Judgment: Compliant

## Regulation 34: Complaints procedure

A complaints log was maintained in the centre which outlined the nature of the complaints made and any actions taken in response.

Judgment: Compliant

## Quality and safety

Inspectors were satisfied that residents were, for the most part, provided with a safe and quality service that was focused on the individual needs of the residents.

Inspectors observed that residents were appropriately supported in line with their personal plans. For example on the day of this inspection some residents were seen to travel to external activities. Residents' participation in education was also facilitated and evidence was seen that the designated centre had links with education providers. Appropriate support was also provided to residents as they transitioned between services to ensure that residents were prepared for these changes.

Each resident had an individual personal plan in place. Inspectors reviewed a sample of these plans and found that they had been informed by detailed assessments. The plans outlined the needs of residents and the supports to be provided to residents to meet these needs. Staff members present during this inspection demonstrated a

good understanding of such needs and supports. Staff were observed by inspectors to provide appropriate support to residents when required.

Support was provided to residents to enjoy the best possible health. Residents had annual assessments carried out and where necessary health care plans were put in place outlining the supports needed for residents. Staff spoken to were aware of the health care needs of residents and how best to support them with these. Residents had access to allied health care professionals. However, some improvement was required in relation to the monitoring of weight and in the follow up of referrals made.

Where required residents had positive behaviour support plans in place which had been informed by assessments by a suitably qualified professional. Inspectors reviewed a sample of these plans and found them to be sufficiently detailed to guide staff. The supports that were outlined in the support plans were known to staff members spoken to, who were able to outline the steps that they would take to promote positive behaviour among residents. This provided assurance that there was a positive approach to the management of behaviour that was tailored to meet the needs of residents living in the centre.

Some restrictive practices were in use in the designated centre and the majority of these were appropriately assessed, monitored and reviewed in line with best practice. Inspectors were informed that there had been a recent reduction in the use of restrictive practices for one resident living in the centre and that this was working well. However one particular physical intervention in use had not been assessed, approved or appropriately reviewed. Staff members had also not been trained in the use of this restrictive practice.

There were appropriate procedures in place to ensure that each resident living in the centre was protected from all forms of abuse. Inspectors saw evidence that reasonable and proportionate measures were taken to ensure the safety of residents where required. Arrangements were in place for the reporting of any concerns to the required external bodies and persons participating in management demonstrated a good knowledge of recent changes in national safeguarding requirements.

Training records reviewed indicated that all staff had received relevant safeguarding training within the previous three years and also in 2018 to reflect changes in national guidance. This provided assurance that staff members had up-to-date knowledge in such areas. During the inspection residents were observed to be comfortable and relaxed in the presence of staff members. Intimate care plans for residents were in place to ensure that appropriate care was provided for such activities. However, it was observed by inspectors that one resident required a more detailed safeguarding plan to clearly outline the supports to be provided to them given the nature of the service provided.

The inspectors found that efforts were being made in the designated to promote the health and safety of residents living there. An up-to-date risk register was in place and each resident, where required, had individual risk assessments in place to promote their quality of life and protect them from harm. Staff members spoken to

aware of the risks related to residents and the steps to take to reduce these risks. Regular audits in the areas of health and safety were also being carried out.

Fire safety systems where in place in the designated centre including a fire alarm system, emergency lighting and fire extinguishers. Such equipment was being serviced at the required timeframes while internal staff checks were also being carried out. Fire exists were observed to be unobstructed on the day of inspection. However, in line with recently published national guidance, fire doors were not in place throughout the designated centre. In the event that a fire took place, this provided for limited containment which did not ensure the safety of residents.

Residents had personal evacuation plans in place which outlined the supports to be provided to residents to assist them in evacuating the centre. Staff spoken to were aware of the contents of these plans and training records reviewed indicated that staff had received some fire safety training. However, when reading one resident's evacuation plan it was noted that the plan outlined various methods of evacuating the resident. From reviewing the plan, talking to staff members present in the centre during the inspection and taking into account the limited number of fire doors, the methods outlined required clarity and review to ensure that this resident could be safely evacuated from the centre if required. It was also noted that a fire drill had not been carried out to simulate night-time staffing arrangements in the centre.

## Regulation 13: General welfare and development

Facilities for occupation and recreation were provided for residents. Residents were supported to engage in education and detailed plans were in place to support residents with this. Activities of residents' choice were facilitated and appropriate support was also provided to residents as they transitioned between services.

Judgment: Compliant

## Regulation 17: Premises

The designated centre was observed to kept in a good state of repair however it was noted that there was one area of paintwork which required repair in the sitting room. The designated centre was presented in a homely manner and was seen to be clean and suitably decorated. Appropriate sleeping accommodation was in place and outdoor recreational facilities were provided for.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

An up-to-date risk register was in place which outlined risks in the centre and the control measures in place to reduce the level of associated risk. Staff members spoken to demonstrated a good knowledge of these.

Judgment: Compliant

## Regulation 28: Fire precautions

Fire safety systems where in place in the designated centre including a fire alarm system, emergency lighting and fire extinguishers. Such equipment was being serviced by external contractors at the required timeframes. Internal staff checks were also being carried out. Fire doors were not in place throughout the designated centre in line with recently published national guidance.

All residents had personal evacuation plans in place outlining the supports to be provided to residents to assist them in evacuating the centre. The contents of these plans were known by staff members. Training records reviewed indicated that all staff had received some training in the area of fire safety.

One resident's personal evacuation plan outlined various methods of evacuating the resident. One method outlined was the use of an evacuation sheet but it was not shown that this was suitable for the resident in question and staff had not received training in the use of this. A second method outlined relied on the presence of suitable fire containment to ensure the safety of the resident in the event of a fire but it was not demonstrated that fire doors were present in the section of the centre where this resident lived.

The personal evacuation plan also made reference to calling for additional assistance to assist staff in the event of a night-time evacuation. However, there was a lack of clarity regarding the specifics of this arrangement and a fire drill had not been carried out to simulate night-time staffing arrangements in the centre. One staff member informed inspectors that they had not participated in a fire drill while working in the centre.

Judgment: Not compliant

## Regulation 29: Medicines and pharmaceutical services

A sample of prescription and administration records were reviewed by inspectors. It was found that the required information such as the medicines' names, the

medicines' dose and the residents' date of birth were contained in these records. Records indicated that medicines were administered at the time indicated in the prescription sheets. Appropriate storage facilities for medicines were also provided for.

During the course of the inspection, a medicines errors was reviewed by inspectors. It was noted that this error did not result in a prompt and efficient follow up to determine how this error took place and to ensure that the error did not happen again.

While reviewing one resident's personal plan it was noted that there were two protocols in place for a PRN (as required) medication which contained different information. This was addressed by the person in charge on the day of inspection.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Residents had personal plans in place which outlined their needs and the supports to be provided to residents to meet these needs. These plans were informed by appropriate assessments and were noted to have been reviewed within the previous 12 months.

Reviews of such personal plans had taken place with the involvement of residents and their relatives. Personal plans were noted to have multidisciplinary input.

However, it was noted that one resident's personal plan had not been updated to reflect a detailed assessment carried out by an occupational therapist in March 2017.

Judgment: Substantially compliant

## Regulation 6: Health care

From reviewing records and talking to staff members inspectors were satisfied that healthcare was provided for the majority of residents in line with residents' personal plans while access was facilitated to allied health professionals if required.

However, inspectors were informed by the person in charge that residents were to be weighted monthly. While reviewing one resident's personal plan it was noted that they had only been weighted three times between July 2017 and March 2018 during which time the resident's weight had increased.

Inspectors were informed that a referral for dietitian had been made in May 2017

but a record of this referral was not adequately documented in the resident's personal plan as addressed under Regulation 21. The resident was still waiting on an assessment at the time of this inspection and the referral was only followed up when inspectors highlighted this to the person in charge.

Judgment: Substantially compliant

## Regulation 7: Positive behavioural support

Residents had detailed positive behaviour support plans in place which had been informed by appropriate assessments. Staff members were aware of the the supports that were to be provided to residents to promote positive behaviour among residents.

The majority of restrictive practices that were in use in the designated centre were appropriately assessed, monitored and reviewed in line with best practice. Efforts were also being made to reduce restrictive practices were possible.

However one particular physical intervention that had been in used since 2016 had not been assessed, approved or appropriately reviewed. Staff members had also not been trained in the use of this physical intervention.

Judgment: Not compliant

## Regulation 8: Protection

There were appropriate procedures in place and measures adopted to ensure that each resident living in the centre was protected from all forms of abuse.

Training records reviewed indicated that all staff had received relevant updated training training. Intimate care plans for residents were in place to guide practice in this areas.

However, given the nature the service provided, a more detailed safeguarding plan was required for one resident to clearly outline the supports to be provided to them to ensure their safety.

Judgment: Substantially compliant

**Appendix 1 - Full list of regulations considered under each dimension**

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Admissions and contract for the provision of services | Compliant |
| Regulation 3: Statement of purpose | Compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 29: Medicines and pharmaceutical services | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Substantially compliant |
| Regulation 7: Positive behavioural support | Not compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Boherduff Services OSV-0005291

## Inspection ID: MON-0020871

## Date of inspection: 29/03/2018

### 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 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br><br>Reg 16(a)<br>The identified refresher trainings in MAPA, Manual Handling and SAM are now up to date for all core staff. Locum staff have been scheduled for refresher trainings as needed over the coming months. There is a system in place to ensure adequate availability of appropriately trained staff on every shift.<br><br>Reg.16(b)<br>Following appointment of a new Person in Charge in January 2018 Supervision is now scheduled regularly for all staff. | |
| Regulation 21: Records | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br>Services will follow Records Management procedures as per organizational policy.<br>A copy of the GP referral for one individual for Dietician assessment has been placed on file.<br>Each individual's file will be reviewed regularly by their Keyworker to ensure ease of retrieval and accuracy of documentation. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>The Service Provider's tool for monitoring will be immediately revised to ensure | |

identification of any non-compliances with the regulations. In addition the Service Provider will develop and deliver training to its internal reviewers to ensure a high standard of audits.

The matters identified relating to physical intervention and fire evacuation have been addressed including the scheduling of the installation of fire safety doors, revision of a Personal Emergency Evacuation Plan for the individual and the scheduling of training for the staff team in the prescribed physical intervention.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
Works have commenced on the repair of the internal chimney to address dampness & deterioration of chimney breast wall. Following completion of these works repairs will be completed to return its appearance to a satisfactory standard.

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| Regulation 28: Fire precautions | Not Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire containment works have been scheduled for the identified area. A system has been put in place to ensure every staff member has the opportunity to participate in firedrills. A simulated night time drill has been completed and the individual's PEEP has been revised. The revised PEEP no longer requires staff to call for additional assistance.

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| Regulation 29: Medicines and pharmaceutical services | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Any future medication errors will be processed in line with the Services procedures which require a prompt response to all such incidents to determine how the incident took place and measures to be put in place to prevent recurrences.

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| 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:
The identified individual's Personal Plan has been updated to incorporate most up to date assessments.

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| Regulation 6: Health care | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 6: Health care:
The Person in Charge will ensure that individuals' weight monitoring is carried out and recorded in a timely manner.

A copy of the GP referral for one individual for Dietician assessment has been placed on file. Each individual's file will be reviewed regularly by their Keyworker to ensure ease of

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| retrieval and accuracy of documentation. | |
| Regulation 7: Positive behavioural support | Not Compliant |
| Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:<br>A Multi-Disciplinary Meeting was held on 10/04/2018 to address the use of this intervention. Training has been scheduled for the staff team in the prescribed physical intervention. | |
| Regulation 8: Protection | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 8: Protection:<br>A more detailed Safeguarding plan has been put in place to guide staff on the supports to be provided to the identified individual to keep them safe. | |

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 31/12/2018 |
| Regulation 16(1)(b) | The person in charge shall ensure that staff are appropriately supervised. | Substantially Compliant | Yellow | 31/01/2018 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 03/07/2018 |
| Regulation 21(1)(b) | The registered provider shall | Substantially Compliant | Yellow | 9/06/2018 |

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| | ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector. | | | |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange | 30/09/2018 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/07/2018 |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Not Compliant | Orange | 26/06/2018 |
| Regulation 28(4)(a) | The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency | Substantially Compliant | Yellow | 31/12/18 |

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| | procedures, building layout and escape routes, location of fire alarm call points and first aid firefighting equipment, fire control techniques and arrangements for the evacuation of residents. | | | |
| Regulation 28(4)(b) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Substantially Compliant | Yellow | 15/07/2018 |
| Regulation 29(4)(b) | 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 medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other | Substantially Compliant | Yellow | 10/04/2018 |

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| | resident. | | | |
| Regulation 05(4)(a) | 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 reflects the resident's needs, as assessed in accordance with paragraph (1). | Substantially Compliant | Yellow | 22/06/2018 |
| Regulation 06(1) | The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan. | Substantially Compliant | Yellow | 01/06/2018 |
| Regulation 07(2) | The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques. | Substantially Compliant | Yellow | 31/12/2018 |
| 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 | Not Compliant | Orange | 31/7/2018 |

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| | practice. | | | |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 04/06/2018 |