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:	Bramble House
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	19 June 2018
Centre ID:	OSV-0005692
Fieldwork ID:	MON-0024270

About the designated centre

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

Bramble house designated centre provides community based living arrangements for up to three adult residents of male gender only. This service provides supports for residents with severe to profound intellectual disabilities and complex needs. The provider identifies that residents living in this centre require high levels of support and assign two staff to work in the centre during the day with a third staff available to support residents in having a full and active life. One waking night staff works in this centre at night time. A full-time person in charge is assigned to this centre. The centre is supplied with one transport vehicle to support residents' community based activities. A large secure garden space is situated to the rear of the property. Each resident has their own bedroom.

The following information outlines some additional data on this centre.

Current registration end date:	18/12/2020
Number of residents on the date of inspection:	3

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
19 June 2018	10:30hrs to 17:30hrs	Ann-Marie O'Neill	Lead

Views of people who use the service

Residents living in this centre were unable to verbally communicate to the inspector their experience of living in the centre. It was demonstrated that residents appeared relaxed and comfortable in their home and enjoyed having a joke and fun with staff during the day. Residents were observed going on outings from the centre during the day while others were supported to return to bed for a nap as they wished. Some residents displayed behaviours of concern during mealtimes indicating they found these periods of time stressful. Staff were observed to be responsive during these times.

Capacity and capability

The provider had systems in place to ensure the centre was regularly monitored and reviewed from a provider level. Inspection findings demonstrated the provider was implementing consistent monitoring and oversight of the service which in turn had led them to identify a more robust operational management arrangement was required to bring about improved quality of life outcomes for residents. The provider had responded to this by putting a full-time person in charge in place for this centre. This arrangement had occurred the week of the inspection and the newly appointed person in charge was involved in a hand over process at the time of inspection.

Overall, the inspector found evidence of a responsive, fit provider capable of monitoring its own governance arrangements and where necessary taking responsive action to improve services provided to residents.

A clearly defined management structure was in place which ensured lines of accountability and authority within the centre. The person in charge had responsibility for this designated centre only. They were supported in their role by a community services manager. The person in charge met the requirements of regulation 14 in relation to relevant qualifications and management experience. The provider had also ensured performance management arrangements were in place to supervise the person in charge and monitor the quality of care in the centre on a consistent and regular basis.

A provider led audit programme was in place to ensure key quality areas of practice were regularly monitored and reviewed. A suite of audits had been carried out and provisions were in place to ensure a six monthly provider led audit and annual report would be completed to meet the regulatory requirements of Regulation 23.

Effective staffing arrangements ensured that the number and skill-mix of staff

working in the centre met the assessed needs of residents ensuring they received the continuity of care and support they required. A high staff to resident ratio worked in this centre each day. A planned and actual roster was in place which identified staff on duty both day and night.

Training and development systems for staff were also effective. Staff had received a formal supervision meeting in the previous months. All staff had received training in mandatory areas such as fire safety, safeguarding vulnerable adults and manual handling. The provider had also ensured staff had received training in other areas specific to residents' assessed needs, for example training in administration of emergency medication for the management of seizures and supporting residents with dysphagia (risk of choking due to compromised swallow).

A sample of incidents reports were reviewed and it was identified that all notifiable incidents had been submitted to the Chief Inspector as required by the regulations.

A directory of residents was in place and the provider had ensured it was updated to reflect a recent discharge and admission of residents to the centre. The provider had also ensured the statement of purpose for the centre was updated to reflect a change in staffing resources for night time and the new operational governance arrangements for the centre. The provider had effective governance arrangements in place to ensure the statement of purpose for the centre was regularly reviewed and met the requirements of Schedule 1 of the regulations.

Regulation 14: Persons in charge

The provider had instated a full time person in charge with responsibility for this designated centre only. They were found to meet the requirements of regulation 14 in relation to experience and qualifications.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured an adequate staff number and skill mix for the centre. A planned and actual roster was in place.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had received training in mandatory training areas such as safeguarding vulnerable adults, manual handling and fire safety. Some further training had been provided in dysphagia management and administration of emergency medication for the management of seizures. Staff had received supervision meetings and these were documented.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was updated during the course of the inspection and found to meet the requirements of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The provider had made necessary operational management governance arrangements and had instated a full time person in charge of the centre. The provider had met their regulatory requirements and had completed an annual report for the centre and a number of quality audit checks to monitor the safety of care provided in the service. Operational management auditing systems were in place which would be the responsibility of the person in charge to complete as per the provider's governance and management assurance systems.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was revised to reflect the new operational governance structure in the centre and submitted to the Chief Inspector in line with the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications had been submitted to the Chief Inspector.

Judgment: Compliant

Quality and safety

It was demonstrated on this inspection that residents were provided a good service but improvements were required in some areas to ensure the quality and safety of care provided to residents. Risk management systems required review to ensure personal risks for residents were robustly managed and evidence based infection control systems were in place.

Staff required training to support residents that presented with behaviours that challenge. Aspects of the premises required some improvement to ensure the centre was maintained to a high standard throughout. Fire evacuation procedures at night time required review to ensure they were as effective as possible and staff were knowledgeable of the procedures in place.

Overall, it was clearly demonstrated residents were experiencing improved quality of life outcomes in their daily lives since moving from Saint Patrick's Centre congregated setting. The provider had ensured residents were provided with a comfortable home which could support residents social care needs and integration with their local and wider community. Some parts of the premises required re-painting and minimal maintenance works to maintain it to a high standard throughout. It was noticeable that there had been some wear and tear since residents had moved into the centre and ventilation in the kitchen required some improvement to prevent a build up of condensation.

The provider had ensured residents received a comprehensive assessment of needs through an allied health professional framework. Residents' personal plans were comprehensive and demonstrated residents assessed needs were reviewed regularly with updated recommendations provided following each review. This ensured residents best possible physical and mental health outcomes were being achieved and continuously monitored to a good standard in this centre. Residents also received improved quality meal provision in line with their assessed dietary requirements and in consistencies that met their needs.

While residents' assessed needs were identified and reviewed regularly it was not demonstrated that the same quality of provision was in place to ensure their identified goals were implemented and reviewed.

Each resident had received a comprehensive person centred planning meeting at

which meaningful goals were identified for them. While this comprehensive work had been carried out, an action plan with review dates and persons responsible for supporting the resident to achieve these goals had not been put in place. It was also not demonstrated that residents were being supported to achieve a meaningful day on a consistent basis. During the course of the inspection the inspector observed a resident did not engage in any meaningful activity during the day and did not have a planned schedule in place for them. Improvement was required in this regard.

The provider had ensured National safeguarding vulnerable adults policies and procedures were in place which were supported by an organisational policy which set out localised reporting procedures. It was also demonstrated that the provider had been responsive and had taken considered action to address a peer-to-peer safeguarding risk in the centre in the months prior to the inspection. The frequency and severity of peer-to-peer safeguarding incidents in this centre had reduced significantly. Where required safeguarding planning was in place but in some instances was now no longer required due to the action taken by the provider.

Residents living in this centre required positive behaviour supports to manage some personal risks and behaviours that challenge. The provider had ensured residents with these needs were supported by appropriately skilled and qualified allied health professionals. Comprehensive behaviour support planning was in place. However, improvements were required. Not all staff had received training in the management of behaviours that challenge which was necessary to ensure quality supports were implemented by staff supporting residents living in this centre on a daily basis.

The provider had ensured appropriate fire safety precautions and containment measures were in this centre and met the regulations. Fire safety equipment was serviced as required and a functioning fire alarm was present in the centre. Evacuation procedures in the centre were not clear however. Staff could not demonstrate to the inspector knowledge of the fire evacuation procedures for the centre at night time. Though fire drills had been carried out they had not included a recently admitted resident. Equally, it was not demonstrated that appropriate evacuation aids had been trialled with residents to ensure they were the most effective strategy possible for timely evacuation purposes.

A risk management policy that met the requirements of the regulations was in place. However, some aspects of it's implementation in the centre required improvement. As part of the provider's overall risk management systems and electronic incident recording system had been implemented across the service and was in place in the designated centre. However, the newly admitted resident's details had not been entered to the system in the centre and therefore incidents that may relate to the resident could not be captured in a timely way.

Some personal risks for residents were not being managed in an effective way and presented as a potential risk to residents and staff particularly at mealtimes and during times when residents used the centre's transport vehicle. Overall, improvement was required to ensure risk assessments provided comprehensive control measures in place and standard operating procedures for staff to implement

in order to protect residents and mitigate risks and potential injuries.

Systems were in place for the management of potential infection control risks but required improvement. Hand drying facilities were not adequate and in one toilet facility unavailable on the day of inspection. More robust infection control management systems were required due to infection control risks presenting in the centre for example, laundering of soiled linen, incontinence management and general hand hygiene requirements.

Regulation 17: Premises

The designated centre presented as clean and homely. Some improvements were required to ensure adequate ventilation in the kitchen area to prevent a build up of condensation. Some areas of the premises required repainting due to wear and tear. Some residents bedroom walls contained holes where picture frames had been moved but the drilled holes not filled in.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Staff had received training to ensure they could provide residents with the necessary supports and nutrition as set out in their nutritional plans. Residents received home cooked meals in the centre which was an improved dietary provision from institutional meal provision when they lived in a congregated setting prior to their move to the centre.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

A resident had recently transitioned to the centre. The transition process was found to have been well managed and in a person centred way with due consideration to the resident's assessed needs.

Judgment: Compliant

Regulation 26: Risk management procedures

It was not demonstrated that there were robust and comprehensive risk management systems in place to manage a personal risk presented by a resident which occurred at meal times. This required comprehensive and robust management by the provider and operational management for the centre to prevent the risks of scalds and serious injury to staff and residents.

Some personal risks that occurred while residents used the transport vehicle. It was not demonstrated clearly what risk mitigation strategies were in place to prevent risks to residents and staff while using the transport vehicle.

The risk register in place identified a wide range of hazards and potential risks for the centre, however it did not contain all risks in the centre for example, infection control risks. Control measures identified were generic in some risk assessments and not adequately detailed to outline the current control measures in place.

Judgment: Not compliant

Regulation 27: Protection against infection

An action from the previous inspection had been addressed. Some improvement was required to ensure staff were appropriately guided in the correct infection control procedures for laundering soiled linen and clothes. Hand drying facilities in both toilet facilities of the centre were not adequate and in one toilet not available.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had ensured appropriate fire safety precautions and containment measures were in place. It was not demonstrated that residents had been assessed for the type of evacuation aid they may require to ensure effective and timely evacuation from the centre. It was also not demonstrated that staff knew the fire evacuation procedure for night time.The effectiveness of evacuation procedures in the centre and not been evaluated for both day and night time to reflect the newly admitted resident to the centre as they had not participated in a drill since their admission to the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had received a comprehensive assessment of need and it was evidenced that these needs were reviewed on a monthly basis through an allied health professional multi-disciplinary process. Person centred goal planning had occurred and it was demonstrated that goals for residents had been identified. Improvements were required to ensure action planning was in place to meet the identified goals for residents. It was also not demonstrated that residents engaged in a meaningful and active day as observed to be the case for some residents on the day of inspection.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare was managed to a good standard and it was clearly demonstrated the provider had measures in place to ensure they achieved their best possible health.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents living in this centre presented with behaviour support needs. Comprehensive behaviour support planning was in place and allied health professional review and recommendations were evident. Not all staff working in the centre had received training in the management of behaviours that challenge. Overall, the environment presented as minimally restrictive with evidence of the least restrictive measures put in place where some were required to manage personal risks for residents.

Judgment: Not compliant

Regulation 8: Protection

The provider had appropriate safeguarding vulnerable adults systems, policies and procedures in place. There had been a reduction in the number of peer-to-peer incidents in this designated centre in recent times due to the provider's review of compatibility issues that had arose some months prior. It was demonstrated the provider had taken appropriate action to address this safeguarding issue.

Judgment: 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	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Bramble House OSV-0005692

Inspection ID: MON-0024270

Date of inspection: 19/06/2018

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The ventilation system was cleaned immediately after the inspection took place on the 20/06/2018. A new ventilation system was fitted in the kitchen area on the 13/07/18. The Health and Safety department has included the cleaning of ventilation systems to the cleaning schedule for all designated centres. The ventilation system is now being cleaned on a weekly basis in the designated centre. On the 20/06/18 the PIC requested the repainting of some areas of the premises and the repair of holes in the bedrooms of people supported. The PIC is awaiting requested quotes for the work being carried out. The toilet seat was changed on the 22/06/18. The PIC requested quotes for dry lining the garden shed on the 20/6/18. As a result of this work being carried out, the garden shed will be used for the storage of files. The PIC and Health and Safety Department will ensure the required work on the premises is carried out and completed by the 01/09/2018.	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: An emergency action plan meeting was held between the Director of Services, Community Service Manager, PIC and the Health & Safety Department on the 21/06/18. The purpose of this meeting was to discuss the management of a personal risk presented by a person supported while the inspection took place.	

The following actions were agreed at this meeting:

- A risk assessment and corresponding care plan were developed for the person supported.
- Identified staff assigned to support the person at all times throughout the day. This duty is recorded at the beginning of each shift on the Shift Planner. A copy of the Shift Planner was sent to the inspector.
- The Behavioural Support Plan for the person supported was reviewed and amended regarding risk management strategies and meaningful day activities.
- The supervision and support guidelines for the person supported were reviewed and include all appropriate support.

All documents were sent to the inspector on the 03/07/18.

Transport

A review of the transport needs for one of the people supported is in process between the PIC and the Health & Safety department.

On the 19/7/18 a Behavioural Support Meeting was held between the Community Service Manager, PIC and staff. The meeting addressed risk mitigation strategies to manage risks to the person supported and staff while using the transport vehicle.

As a result of this meeting:

- The Behaviour Support Plan for the person supported was reviewed. This plan includes social stories on how to support the person when using the transport
- A transport risk assessment was completed. The transport risk assessment guides staff to the seating arrangements for the person supported.

Office

A review regarding the office desk in the sitting room is in process between the CSM, PIC and staff team. In the meantime, staff will use the guidelines within the Behavioural Support plan to redirect the person supported. A challenging behaviour risk assessment was completed for the person supported on the 11/07/18.

Risk Register and Assessments

Behavior review meetings are scheduled on a monthly basis in the designated centre where incidents and interventions are discussed between Community Service Manager, PIC and keyworkers.

Further to the above reviews, all risk assessments were reviewed by the PIC and staff team also. This process was completed on 20/7/18. The Community Service Manager monitored the review of risk assessments to assure they were specific and detailed to outline the current control measures.

The PIC and staff team will review and monitor all risk assessments on a three monthly

basis or immediately where required.

The PIC and staff reviewed the full risk register on the 02/07/18. The infection control risks are now included in the risk register.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

Towel rails are now installed in the bathroom/toilets. The PIC will ensure that towels are available and changed in line with the Infection Control Policy.
Please find attached the Infection Control Policy.

The Standard Operating Procedure for laundering soiled linen and clothes was reviewed and updated on the 11/07/18.
Please find attached the updated Standard Operating Procedure.

Regulation 28: Fire precautions	Not Compliant

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

All PEEP's (Personal Evacuation Egress Plan) and the CEEP (Central Evacuation Egress Policy) has been reviewed and sent to the inspector on the 03/07/18.
The review includes:

- the type of evacuation aid the person supported may require
- the evacuation procedure
- the evacuation procedure for night time

There was a simulated night time fire evacuation procedure completed on the 19/07/18. A real day time fire drill was carried out on the 24/07/18 and a real night time is scheduled for the 31/07/18.

The PIC generated a timetable for the designated centre. Simulated and real time night time fire drills are going to be carried out on the 7th of each month, simulated and real time day time fire drills on the 14th of each month. This had been added to the house diary and email reminders will go to all staff. This will also be outlined in the reviewed delegated duties list.

All details regarding fire drills are recorded on the Fire Evacuation Drill form.
Some of the details included are:

- Dates, times and staff involved in the drill
- People supported and their reactions
- Learning from the drill

Please find attached the Fire Evacuation Drill form.

A Standard Operating Procedure is in place between two designated centres to ensure that the CEEP is appropriate for all staff.

The PIC is organising a fire drill on the 31/07/18 where staff from the other designated centre has to respond, as outlined in the Standard Operation Procedure between the two designated centres.

The local Fire department was contacted by the PIC on the 21/06/18 to review the fire plans and evacuation procedures for the designated centre. Due to lack of resources in the Fire Department the PIC was advised to contact the Fire trainers, who train St. Patrick's Centre (Kilkenny) staff for support. The PIC is waiting for a date to be confirmed when the Fire trainers visit the designated centre and attend a fire drill.

There will be a full review of fire evacuation procedures and training on documentation of fire drills for all staff in a team meeting on the 07/08/18.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

On the day of the inspection the Inspector observed a person supported as not being engaged in a meaningful and active day.

There is a Behavioural Support Plan in place for the person supported which advises staff how to respond and support the person through a day with challenging behaviour. The person supported has also an activity plan in place, outlining meaningful day activities which are connected to the person's roles.
On the day of the inspection staff could not fully support the person to engage in his meaningful day activities, as the challenging behaviour was dominating.

The PIC and keyworkers are reviewing the activity and the Behavioural Support plan for the person supported. This review will be completed by the 27/07/18 and both plans will be updated accordingly.

In the team meeting on the 10/7/18 the standards of valued roles and meaningful day activities were discussed with the staff team. The PIC and staff team explored the improvement of action planning for each person supported to meet the identified goals. Ideas about meaningful day activities and evidence based documentation were discussed and recorded in the minutes of the meeting. In this instance monthly Quality Conversations between the PIC and keyworker will monitor progress and timeframes.

Personal Plan Pathway

Within the Personal Plan Pathway clear long and short term goals and roles are established for each person supported. Each person supported already had visioning meetings with the Community Transition Coordinators, PIC and keyworker.
As a result goals and roles were identified and action plans identifying responsibilities

and agreed timeframes were developed.

The goals are reviewed on a three monthly basis with a visioning meeting review every six months. The “conditions for success” form will evidence the measurable outcome.

The key worker is supported by the PIC and Community Service Manager through Quality Conversations to achieve the goals with the person supported through mentoring and monitoring. There is a monthly review of Person Planning with the key worker.

Within the Person Supported Pathway to MDT each person has a monthly in house review meeting, where current issues and needs are discussed and agreed. The PIC and keyworker attend an annual MDT review meeting.

All these meetings ensure that the supported persons personal plan is not only subject of a review by the keyworker, but also by appropriate health care professional to reflect changes in need and circumstances.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

A behavioral support review meeting with the staff team was held on 18/07/2018 to review and update the people supported’s Behavioral Support Plan.

Incident analysis is carried out on a regular basis to ensure changes in intervention requirements are being documented. Behaviour review meetings are held monthly.

All Staff are booked in for Studio 3 training to manage behaviors that challenge. All staff will have Studio 3 training completed by 08/08/18.
Please find attached the training schedule for the designated centre.

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 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	22/06/2018
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/09/2018
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.	Not Compliant	Orange	03/07/2018
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated	Substantially Compliant	Yellow	11/07/2018

	infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
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	03/07/2018
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	19/07/2018
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.	Not Compliant	Orange	08/08/2018