



## Office of the Chief Inspector

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

Name of designated centre:	Rosanna Gardens
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	23 September 2019
Centre ID:	OSV-0001711
Fieldwork ID:	MON-0022430

## About the designated centre

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

Rosanna Gardens is a designated centre, operated by Sunbeam House Services and is located in Co. Wicklow. The centre can provide support for up to 11 adults between the ages of 18-90 years old. This designated centre offers support to men and women with mild to moderate intellectual disability and who may display responsive behaviour. Residents living in this designated centre are generally independent in their personal care or require a low level of support. Residents do not need any additional support in relation to their mobility. This centre provides a high level of supervision for residents who require it, both in the designated centre and in the community. The designated centre comprises of three distinct areas each with their own kitchen and living/dining area. Each resident has their own bedroom, and some residents have their own living space also. The centre has a gym/games room, laundry facilities, a large garden area and an outdoor room for activities. The staff team working in this designated centre consist of nursing staff, social care staff and care assistants. The centre is managed by a full-time person in charge, who has support from a deputy manager. A de-congregation process is underway in the designated centre which will have a beneficial outcome for all residents and further enhance community participation and achievements of personal goals. The centre is not open to new admissions.

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

Number of residents on the date of inspection:	11
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

### **1. Capacity and capability of the service:**

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

### **2. Quality and safety of the service:**

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

**This inspection was carried out during the following times:**

Date	Times of Inspection	Inspector	Role
23 September 2019	09:10hrs to 18:10hrs	Louise Renwick	Lead

## Views of people who use the service

The inspector met with nine of the 11 residents on the day of the inspection, and spoke specifically with six residents about their experience living in the centre, the supports they were receiving and how they liked to spend their day. The inspector also received seven questionnaires completed by residents (with the support of staff) that reflected their views of the designated centre.

Overall, residents told the inspector that they were happy with the care and support they were receiving while living in the designated centre. Some residents told the inspector about new skills that they had been supported to learn, and things that they had achieved over the course of the year. For example, some residents now managed their own finances and administered their own medicine. Some residents told the inspector that they had been supported to get paid employment and were taking part in more activities in their week. Residents told the inspector that there was more staff available to support them in the centre during the daytime and in the evening time, and this meant that they had more staff attention and had more freedom to choose how to spend their day.

Residents told the inspector that they felt safe in the designated centre. However, residents did not always get along with each other. This was also reflected in the questionnaires. Some residents wished to move on from the designated centre and were waiting to move to a new home. Residents were fully aware of the plans for four residents to move out of the centre in the coming months, and felt that this would make the centre a quieter and more pleasant place to live. Some residents who were staying in the designated centre were planning to move bedrooms once these moves happened, and looked forward to making these changes that would offer them more space and privacy throughout the day.

Some residents spoke to the inspector about their plans to transition on from the designated centre, and expressed frustration at the length of time this move was taking. Residents had raised complaints regarding this, and were satisfied with the response they had received in relation to their complaints. Three residents were awaiting a move to a new home which was initially due to happen by March 2019. However, due to delays, outside of the control of the provider, this time-frame had been extended. Another resident due to transition from this designated centre to another designated centre operated by the provider, told the inspector as part of their transition planning, they were visiting the other designated centre for meal times and overnight stays with plans to move there in the coming months.

The inspector observed some residents returning from social outings, such as visits to places of historical interest and museums, swimming, day services and local errands. Some residents were relaxing in the centre watching the news and weather, spending time in their apartments or living space.

## Capacity and capability

The provider and person in charge demonstrated that they had the capacity and capability to operate this designated centre in line with the regulations and standards, and to provide a safe and comfortable home for residents living there. The provider had a plan in place to de-congregate the designated centre and to move some residents into more suitable centres in order to reduce the number of residents living in Rosanna Gardens. Until these transitions took place, the provider and person in charge had improved the care and support that residents were receiving while living in the designated centre, and this inspection found an increase in compliance with the regulations and standards from previous inspections.

This designated centre is currently registered with two restricting conditions attached to the registration. The restricting conditions were applied to the registration of this centre to ensure the provider carried out their plan to reduce the number of residents living in the centre, and to ensure an improvement in compliance with the regulations and standards. The provider had not met one of the restrictive condition to move residents out of centre by the deadline identified, and had applied to extend this time frame. Delays with this transition were due to circumstances outside of the control of the provider.

The provider had however, had ensured residents were supported to develop skills that would support their transition from the centre while waiting for the new designated centre property to be made available and registered. Residents were kept informed of the progress of their new home, and had been involved in decisions such as how the house would be decorated and which bedroom they would like. The provider had responded to complaints raised by residents in relation to the delay in this transition, and were actively working on progressing this move on behalf of residents. The provider had maintained a consistent briefing of their progress with the Office of the Chief Inspector of Social Services and had progressed the de-congregation of the centre where possible with an imminent plan to transition three residents from the centre in a short time-frame following this inspection.

The designated centre was managed by a suitably qualified and experienced full-time person in charge, who had support from a deputy manager. There was a clear management structure in place in the designated centre, with the person in charge reporting to a senior services manager, who reported to the Chief Executive Officer (CEO). At the time of the inspection, a new person had been appointed to the role of interim CEO. They had plans to visit to the designated centre in October in order to meet residents and staff.

There were management systems in place to ensure the care and support provided to residents were effectively monitored. The provider had completed an annual review of the designated centre in November 2018, and had ensured six-monthly unannounced visits to the centre, on their behalf, had occurred. The annual review and unannounced visits resulted in a report and action plan to identify any areas in

need of improvement. The inspector found that the person in charge and senior manager had been responsive in taking action to any identified areas, and this had resulted in improvements to documentation, how information was recorded and the monitoring of residents' finances. There was a schedule of audits completed over the course of the year in areas such as health and safety, household chores and management, medicines management and staff knowledge. Actions raised as a result of these audits were also found to have been addressed in a timely manner by the person in charge.

The provider had ensured staffing resources had been put in place in response to residents' assessed needs. Residents were supported by a stable and consistent staff team, made up of psychiatric nurses, general nurses, intellectual disability nurses, social care workers and health care assistants. Staff knew residents well, and in general residents felt that they could talk to any member of the team and that their views would be listened to. Staff had been given person-specific training as well as a suite of mandatory training in order to meet the assessed needs of residents. There was a system in place to monitor the training needs and training achievements of staff, and this was maintained by the person in charge.

The provider had prepared a written statement of purpose in line with the requirements of the regulations. The statement of purpose clearly set out the aim of the designated centre, the needs that could be met in the centre and the plans for de-congregation in the future. The statement of purpose outlined that as the number of residents reduced in the designated centre, no new admissions would take place. The information on staffing, facilities and the care and support in the statement of purpose and function were seen to be an accurate reflection of the arrangements noted on the day of inspection.

Residents told the inspector that they knew how to raise a complaint, and were comfortable voicing their concerns to members of the staff team or management. There was a complaints policy in place in the designated centre, and information was on display in the centre on how to make a complaint and the details of the complaint officer. The inspector reviewed the complaints log and found that complaints were recorded, investigated and responded to by the relevant person. The records reviewed indicated persons making complaints had been satisfied with the response. This was also noted in residents' questionnaires.

The provider had prepared in writing and implemented a range of policies as required by schedule 5 of the regulations. While the national policy on safeguarding vulnerable persons at risk of abuse was available in the centre, there was an absence of an organisation specific policy on the prevention, detection and response to abuse to outline how national policy was being implemented in this centre. Some other policies as required by the regulations required updating, to ensure they were in line with best practice and were reflective of current good practice in the designated centre. For example, the policy on restrictive procedures and the provision of behaviour support.

Overall, the provider and person in charge demonstrated capacity and capability to operate and manage the designated centre in a manner that was meeting residents'

needs and there were systems in place to continuously evaluate, monitor and improve the quality of the care and support being delivered to residents living in Rosanna Gardens.

## Regulation 15: Staffing

The registered provider had ensured that there was a sufficient number of suitably skilled and qualified staff working in the designated centre. The number of staff working in the centre each day and night was based on the size of the centre and the assessed needs of residents.

The staffing arrangements had been reviewed and amended in response to residents' needs. For example, additional staffing was now in place in the evening time in one of the units and residents felt this offered them more staff attention and time.

At the time of this inspection, there were additional staff working in the designated centre. This was to support the future transition of residents and to ensure consistency once some residents moved out.

There was a stable and consistent staff team available to support residents. Some residents had known staff for many years, and said that they had a good relationship with the team that supported them.

There was a planned and actual staff roster in place, which was maintained by the person in charge. The rosters reflected which staff were on duty during the day and night time.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to appropriate training, including refresher training to enable them to best meet residents' needs.

Mandatory training was identified through the provider's own policies, and staff were offered refresher training after a set period of time.

Staff working in this location had been trained in specific areas that would better equip them to support residents and manage any potential risks.

There was a system in place to monitor the training needs of the staff team, and to



ensure all training was delivered, recorded and refreshed as outlined in the provider's policies.

The person in charge carried out monthly audits on staff knowledge in key areas, to ensure training information around best practice was retained.

Information on the Act, regulations and standards was available to the staff team in the designated centre.

Judgment: Compliant

### Regulation 23: Governance and management

There was a clearly defined management structure in the designated centre and organisation overall, that identified lines of reporting and accountability.

There were management systems in place in the designated centre to ensure the service was safe, appropriate to residents' needs and consistently and effectively monitored.

The provider had carried out an annual review of the designated centre in November 2018, along with six-monthly unannounced visits on their behalf. Reviews and visits resulted in clear action plans to address any areas of improvement.

Judgment: Compliant

### Regulation 31: Notification of incidents

The inspector found that any incident that was required to be notified to the Authority had been submitted within the time-frame indicated in the Regulations.

Judgment: Compliant

### Regulation 34: Complaints procedure

Residents knew how to raise a complaint, and were comfortable bringing complaints to the staff team or person in charge.

The provider had a complaints policy and an effective complaints procedure that was on display in the designated centre. This information included who was the

complaints officer and how to raise a complaint.

Complaints were recorded, investigated and responded to by the relevant person. The records reviewed indicated persons making complaints had been satisfied with the response.

Judgment: Compliant

#### Regulation 4: Written policies and procedures

The provider had prepared in writing and implemented a range of policies as required by schedule 5 of the regulations. However, there was an absence of a centre specific policy in relation to the prevention, detection and response to abuse.

Some policies required updating and review to ensure they reflected best practice, and were inclusive of the care delivery in place in the designated centre. For example, the policy on restrictive interventions and positive behaviour support.

Judgment: Substantially compliant

#### Quality and safety

The provider and person in charge demonstrated capacity and capability to operate and manage the designated centre in a manner that was meeting residents' needs. The provider had plans to reduce the number of residents living in the designated centre in order to improve the quality of life for residents. This inspection found that while residents were awaiting these changes, the provider and person in charge had improved the quality and safety of the care and support being delivered in the centre through increased multi-disciplinary input, effective assessments and plans, an increase in staffing and additional training for staff and residents in key areas to promote safety and greater independence.

Residents had very active lives and had meaningful activities to take part in each day. On the day of inspection, a number of residents were out taking part in different activities. Residents had access to a day service operated by the provider if they so wished and attended at various times and days throughout the week. Some residents had paid employment and had been supported by the staff team to improve their skills in order to achieve this. Residents enjoyed an active week, held various roles and took part in activities that they had identified through the personal planning process. For example, swimming, going to cinema, going on holidays, having a spa day, visiting museums and historical places, taking part in advocacy groups, visiting family and friends and staying connected with their natural support network. Some residents told the inspector about goals that they were

working on to improve their independence and to increase their opportunities to have more choice and control over their daily lives. For example, learning to manage their own finances and administer their own medicine.

There was evidence that risks were being well managed in the designated centre through formal measures of identifying, assessing and reviewing risks. Some improvements were required to the documentation to ensure risk assessments contained all of the specific information about the control measures in place to alleviate risks. The person in charge told the inspector that this would be included to enhance the information available. That being said, staff and management had a very good understanding of the specific control measures, and knew how to supply supports on a daily basis in order to keep all residents safe. Staff had received specific training in order to enhance their skills and understanding of specific risks and how to manage them effectively.

Residents' health, social and personal needs were assessed and planned for in the designated centre. Each resident had a personal plan, which focused on independence building and skills teaching as well as personal goals and aspirations. Progress in relation to agreed goals was reviewed regularly and well documented. Some residents told the inspector about what they had recently achieved. For example, some residents had obtained their own bank card and were learning how to use the automatic teller machine (ATM) independently.

Residents health care needs were clearly identified and planned for through a health and well-being plan, which set out both long-term and short-term health goals and plans. This had been improved upon since the previous inspection. Residents who required support for their mental health, had access to the local mental health community team, their own psychiatrist and psychology services if required. The provider had recently employed a psychologist to work as part of the multidisciplinary team for the organisation.

Since the previous inspection in February 2018 there were much stronger safeguarding systems in place to safeguard residents from abuse or harm in the designated centre. Any incident of a safeguarding nature had been recorded, responded to and reported to the appropriate agency. Safeguarding plans were drawn up and put in place in order to keep residents' safe. These plans were reviewed regularly and known to residents and the staff team. Residents were given information on how to keep safe through a safeguarding passport that was easy to read and discussed with residents through their key-worker meetings. Some residents had received training in personal development and sexual education and had taken part in anti-bullying courses. For residents who did not always get along with each other, restorative mediation had been put in place along with written agreements between peers to promote respectful and kind interactions.

In the previous 12 months, three notifications of peer-to-peer safeguarding incidents had been submitted to the Office of the Chief Inspector of Social Services. It was noted there had been an appropriate response each time by the person in charge with additional measures put in place to keep people safe. In the past two years, there had been a significant decrease in the amount of peer-to-peer incidents

occurring in the designated centre. For example, one resident had 74 incidents in 2017 of a peer causing them upset or harm, this had reduced to six incidents of the same nature in 2018.

In order to decrease the number of residents living in the centre and promote better peer relationships, the provider was supporting a number of residents to transition to other centres to live as part of an overall de-congregation process. While awaiting these changes the person in charge and staff team had worked collaboratively with residents and the multidisciplinary team to improve the safeguarding mechanisms in the designated centre, and residents told the inspector, while they did not always get along with their peers, they felt safe living there. Any safeguarding allegation, suspicion or concern had been notified to The Office of the Chief Inspector for Social Services in line with regulatory requirements.

Since the previous inspection, significant improvements had been made in relation to the number of restrictive interventions in place in the designated centre. A comprehensive review of all restrictions had been undertaken by the person in charge and the organisation's Human Rights committee. This review had resulted in historical restrictions being re-evaluated and questioned through a risk based approach. For example, the use of closed circuit television (CCTV) had reduced along with environmental restrictions such as locked doors and windows.

Residents' medicine had been reviewed and the use of both PRN (as required) medicine and some routine medicines that could be seen as restrictive had been reduced or removed. For residents who were planning to move out of the designated centre, restrictions had been gradually reduced along with an increase in skills teaching to support residents to become more independent. The inspector reviewed the restraint register in the designated centre and found that restrictions in place were well assessed, discussed and consented to with residents and reviewed regularly by the person in charge, human rights committee and the wider multi-disciplinary team.

Overall, this inspection found a high level of compliance with the regulations and standards. The provider and person in charge were operating and managing the centre in such a way that was meeting residents' needs in a person-centred manner. The provider was actively working on supporting residents' plans to move out of the designated centre, and the provider continues to keep the Chief Inspector updated on a monthly basis on the progress of this.

### Regulation 13: General welfare and development

Residents were in receipt of appropriate care and support in accordance with evidence-based practice, and with regard to residents' assessed needs and wishes.

The provider had ensured residents had access to facilities for occupation and recreation, and opportunities to take part in meaningful activities in accordance with

their interests and needs.

Residents were supported to develop and maintain personal relationships with the wider community.

Judgment: Compliant

### Regulation 26: Risk management procedures

There was a policy in place in the designated centre in order to ensure risks were identified, assessed and managed to promote safety. There was an escalation pathway in place to ensure any risks that were assessed as being high were reviewed regularly.

There was a system in place to record and respond to adverse events and incidents, and there was good oversight arrangements in place to ensure any incident recorded was reviewed by the person in charge and senior manager, and any additional measures were identified and put in place.

From review of risk assessments, the inspector found that risk control measures were proportionate to the risk identified, and the process of assessing and managing risk was respectful of residents' rights. Control measures put in place to address risk were discussed with residents and residents had a good understanding of the supports that were in place to manage risk.

Staff had received training to support them to meet residents' needs and manage specific risks. Staff had a good understanding of the control measures in place. Some improvements were required to the documentation to ensure risk assessments contained all of the specific information about the control measures in place to alleviate risks.

Judgment: Substantially compliant

### Regulation 28: Fire precautions

The registered provider had ensured that there were effective fire safety management systems in place. There was a fire detection and alarm system in the designated centre, fire fighting equipment, emergency lighting, emergency exit lighting and fire containment measures. All equipment in place was checked and serviced by a relevant fire professional on a routine basis, and records of this were well maintained.

Staff had received training in fire safety, and this training was refreshed routinely. Residents knew what to do in the event of an emergency and regular evacuation

drills were completed at different times of the day and night.

Judgment: Compliant

### Regulation 29: Medicines and pharmaceutical services

The provider and person in charge had implemented new systems in the designated centre for the prescribing and administering of medicine in order to improve practice and to ensure safe medicine management. Medicine management was routinely audited both by internal and external staff. Improvements had been made to stock checking and double checking of medicine, and changes had been made to simplify the administration of medicine and reduce the likelihood of errors.

Residents had access to a pharmacist of their choice and records were well maintained.

Medicine was securely stored in the designated centre, and a system of segregation for out of date or returned medicine had been implemented.

Following an assessment, residents were encouraged and supported to take responsibility for their own medicine in accordance with their wishes.

Judgment: Compliant

### Regulation 5: Individual assessment and personal plan

Residents' needs were assessed in the designated centre by the staff team, allied health professionals and the wider multi-disciplinary team (where required).

Assessments were carried out as required, to reflect changes in need and circumstances.

Residents had a personal plan to reflect their individual needs and wishes, and these were developed through a person-centred approach.

Personal plans were reviewed regularly, and these reviews were inclusive of advice from member of the multi-disciplinary team.

Judgment: Compliant

### Regulation 6: Health care

Residents had access to their own General Practitioner (GP) and availed of a yearly annual medical check-up, as well as taking part in national screening programmes if they so wished.

Residents had access to the primary care team by referral through their GP. Residents had access to a range of allied health professionals, who were working together as a team in order to ensure the appropriate supports were planned for and put in place. For example, access to allied health professionals employed by the provider such as physiotherapy, occupational therapy and counsellors.

Residents also had access to allied health professionals employed on a consultancy basis such as psychiatry and psychology.

Judgment: Compliant

### Regulation 7: Positive behavioural support

The person in charge had ensured that staff had the knowledge and skills to respond to behaviour that is challenging, and to support residents to manage their own behaviour positively.

Staff had received training in de-escalation and intervention techniques along with specific training to support particular behaviour of concern.

The person in charge and staff team had reviewed all restrictive interventions in the designated centre, along with the human rights committee and there had been a significant reduction in the amount of restrictive interventions in use. Restrictions that remained in place were well assessed, discussed with residents and consented to and reviewed regularly by the person in charge, human rights committee and the wider multi-disciplinary team.

Efforts had been made to identify and alleviate the cause of any behaviour that was challenging and residents had written behaviour support plans in place, which were created and reviewed by the wider multi-disciplinary team on a regular basis.

Judgment: Compliant

### Regulation 8: Protection

The provider had ensured that residents were assisted and supported to develop the knowledge, self-awareness, understanding and skills for self-care and protection.

Through improved safeguarding processes, the provider was protecting residents

from harm and abuse. Staff had received training in safeguarding vulnerable adults, there were improved staffing arrangements in place to supervise and support residents throughout the day and night and improvements to the specific supports in place for residents was resulting in less incidents between peers.

The provider was actively working on transition plans for a number of residents to reduce the number living in the designated centre, and to create a more pleasant living environment.

Any safeguarding concern had been recorded, responded to and reported in line with best practice and national policy. Safeguarding plans in place were successful at promoting residents' safety.

Judgment: Compliant



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

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Views of people who use the service</b>	
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
<b>Quality and safety</b>	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

# Compliance Plan for Rosanna Gardens OSV-0001711

Inspection ID: MON-0022430

Date of inspection: 23/09/2019

## 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 4: Written policies and procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:</p> <p>Restrictive interventions – works are currently underway with this policy within SHS and confirmation received from Senior Manager of Quality and Compliance that this will come into effect 31st December 2019.</p> <p>Positive Behavior Supports - SHS have now fully adopted the HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy. The actions stated below were introduced by CSM with oversight and guidance from Senior Social Worker SHS as per Policy mentioned above.</p> <ul style="list-style-type: none"> <li>•The HSE Awareness training continues for staff on a monthly basis.</li> <li>•Senior Social Worker has developed a supportive checklist document for CSMs to utilize while inducting new staff. This is currently taking place in Rosanna Gardens for all new staff. This includes cues to follow such as to ensure the staff member is aware of Safeguarding &amp; Protection policy, designated officers, and each client’s safeguarding plans (if applicable), etc.</li> </ul> <p>CSM utilizes this checklist document and follows up with staff upon completion.</p>	
Regulation 26: Risk management procedures	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management procedures:</p> <p>In consultation with the Psychologist on 10/10/2019, all Risk assessments reviewed in</p>	

relation to specific information about the control measures that are in place to alleviate risk.

Positive Behavior Support plans updated to highlight appropriate responses by staff members in the Reactive strategies section of The Positive Behavior Support Plan. In addition to this all risk assessments reviewed and updated where relevant. Missing Person's Protocol also reviewed with oversight from the psychologist and recommendation made to include additional information to protocols. All updates complete and reviewed by relevant professional.

## 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 26(1)(b)	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 risks identified.	Substantially Compliant	Yellow	10/10/2019
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	16/10/2019
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3	Substantially Compliant	Yellow	31/12/2019

	years and, where necessary, review and update them in accordance with best practice.			
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