Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Adult Respite Service
Name of provider:	St Christopher's Services Company Limited by Guarantee
Address of centre:	Longford
Type of inspection:	Announced
Date of inspection:	12 June 2019
Centre ID:	OSV-0001841
Fieldwork ID:	MON-0023768

About the designated centre

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

Adult Respite Service is currently providing emergency accommodation to four adult residents on a full time basis, until such a time as a suitable centre is identified and registered for occupancy. The Adult Respite Service is a large Dormer style Bungalow located in a quiet housing estate. On the ground floor, there is a bright entrance hall, four bedrooms, of which two are ensuite, an accessible large kitchen and dining area, sitting room, snug/relaxation area and office space. The main bathroom has a Jacuzzi bath and shower facilities. All bedrooms are decorated according to the wishes of the resident and take into consideration their taste and preference thereby ensuring personalisation and comfort. There is an accessible sensory garden and outdoor seating area at the back of the residence. The Adult Respite Service aims to meet the support and care needs of four adult residents who may present with needs related to moderate to profound intellectual, physical and sensory disability, behaviours of concern and mental health conditions. Currently, there are two male adult residents on a full time basis, one female adult resident on a full time basis and one female adult resident on a part time basis. Residents are supported by one Nurse, Social Care workers and Support Workers under the direction of the Person in Charge in delivering a person centred model of service provision. Each individuals needs are identified through the support/care planning assessment process in consultation, where possible, with the resident, next of kin/advocate and relevant allied health professionals.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
12 June 2019	10:00hrs to 17:00hrs	Eoin O'Byrne	Lead

Views of people who use the service

The inspector met with two out of the four residents residing in the centre during the inspection. The inspector sat with one resident at the kitchen table. The resident showed the inspector their tablet device and used the visual aids on the device to talk about their preferred activities and what they did when they went home to visit their parents. The resident was supported by staff members briefly and was noted to have positive interactions with those that were supporting them.

The inspector met with another resident who joined the conversation in the kitchen. The resident was curious as to why the inspector was there and to when they would be going home. The inspector explained why they were there and to when they would be leaving.The resident then left with a member of staff to review which staff were working in the coming days.

During the course of the inspection the inspector noted complaints' from residents' in relation to the peers that they were currently living with. Residents complained of the noise levels in the centre due to other residents and that this was negatively impacting upon them. There had also been incidents of peer to peer aggression submitted by the provider to the authority.

Capacity and capability

There was a clearly defined management structure in place which supported many positive aspects of the service. There was also evidence of some effective systems of oversight of the centre and the audit system was being used effectively to drive continuous improvement in a number of areas. However, the provider had not adequately addressed the compatibility issues which had arisen in the centre.

The provider has identified compatibility issues regarding the residents residing in the designated centre. The residents moved to the centre, which was set up as a respite service, on temporary basis in February 2018. The provider had attempted to source alternative accommodation for the residents but this had not been sourced at the time of the inspection. Inspectors were notified of computability issues between residents during the inspection and also through notifications submitted by the person in charge. Residents have presented with intimidating behaviours towards one another and noise levels in the centre have also caused some distress for residents. These compatibility issues have impacted on the provider's capacity to provide a quality service that meets the identified needs of the residents.S

Some aspects of the service were well managed. The inspector found a clearly

defined management structure in place for the designated centre. The person in charge was supported by the person participating in management (ppim) and the residential and respite coordinator. The inspector viewed supervision records between the person in charge and ppim which showed that that support was being provided. The person in charge also referenced that they were receiving adequate support from senior management.

The provider had made appropriate arrangements for the role of person in charge which is a key management role in the centre. The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre. The person in charge had shown that they were responding to adverse incidents between residents and they were submitting notifications within the three working days as set out in the regulations. The person in charge had also ensured that quarterly and six monthly notifications were being submitted as set out in the regulations.

The audit system was being used to drive improvement. A schedule for audits that included, medication management, risk management personal plans, and person centred plans. Members of the staff team were assigned auditing roles and the person in charge had oversight of the audits taking place. Inspectors observed that some monitoring practices required attention such as that of the behaviour support documents. Elements of these documents had been reviewed and updated but this was not easily identifiable and this meant that key information might not be communicated to staff effectively.

The provider had ensured that an annual review of the quality and safety of care and support in the designated centre had taken place. Inspectors noted that the residents and their family members had been involved in gathering information for this review. The inspector also noted that staff members had contributed to the review, the review referenced staff members concerns regarding the mix of residents residing in the centre and the impact they were having on one another. There was an easy read version of the review available to residents. The inspector noted that the person in charge and senior management team had set actions following the review and were working towards completing same. This showed that the provider was consulting with residents and family members with the aim of improving the service.

The provider had also carried out unannounced visits to the centre as per the regulations. The last unannounced visit had taken place in April 2019. The provider had developed a report from this activity and actions had again been set. The provider was consistent in setting actions in relation to the incompatibility of the residents currently residing in the centre. The provider had completed compatibility and suitability assessments for residents that highlighted this. However, the issue had not been successfully addressed and this was resulting in living conditions which were having a negative impact on the residents.

The registered provider was ensuring that effective arrangements were in place to support develop and performance manage the staff team. The staff team were

receiving regular supervision and there was evidence of regular team meetings taking place where learning was being promoted by the person in charge. The registered provider had ensured that the qualifications and skill mix of staff was appropriate to the needs of the residents. There was a deficit of two full-time staff members; this deficit was being filled by locum staff members. A review of the centres actual roster showed that the residents were receiving continuity of care and support as the same locum staff members were being utilised. The inspector reviewed a sample of the staff members' files and found them to meet the required information and documents set in schedule 2.

The person in charge had ensured that staff members had access to appropriate training as part of continuous professional development. The inspector reviewed the training schedule plan for the centre and found that the staff team had received the necessary training to meet the needs of the residents.

The provider had ensured that the residents and their families were aware of the complaints and compliments procedures and were being supported to lodge complaints and compliments. There was reference made to a family member submitting a compliment in relation to the care being provided to their family member. There was an easy read version of the complaints procedure available to residents. Visual aids were used to explain the process in a step by step approach. There was evidence of residents making complaints regarding their fellow peers. One resident made three separate complaints regarding his peers in May of this year. There was another similar complaint in early June regarding a resident being unhappy living with their current peers. On review of the complaints, the inspector found that the complaints had been submitted to the complaints officer but the documentation of how complaints were being managed and if the complainant was satisfied was unclear. This was discussed with the residential and respite coordinator who acknowledged this and informed the inspector that a new system was due to be introduced that would address these issues.

Overall the provider and person in charge were striving to provide a safe and quality service to the residents. However, the incompatibility issues regarding the residents have meant that this has not been achievable.

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that the qualifications and skill mix of staff was appropriate to the needs of the residents.

The inspector reviewed a sample of the staff members' files and found them to meet the required information and documents set in schedule 2. The inspector noted positive interactions between the staff members and residents during the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff members had access to appropriate training as part of continuous professional development.

Judgment: Compliant

Regulation 19: Directory of residents

The registered provider had established a directory of residents in the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. There was evidence of some effective systems of oversight of the centre and the audit system was being used effectively to drive continuous improvement in a number of areas.

However, the management systems were not adequately addressing the compatibility issues which had arisen in the centre. The current group of residents transitioned to this centre in February 2018 on an interim basis as a result of an urgent situation. The provider had identified that the current resident mix was not appropriate and that residents' were impacting negatively on one another. The current mix of residents had resulted in the provider failing to ensure that the service is appropriate to the needs of the residents.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose containing the information set out in schedule one of the regulations. The registered provider had also updated the statement of purpose in relation to the centre providing emergency temporary accommodation to the four residents.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations. The person in charge had also ensured that quarterly and six monthly notifications were being submitted as set out in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had ensured that the residents and their families were aware of the complaints and compliments procedures and were being supported to lodge complaints and compliments.

There was evidence of residents making complaints regarding their fellow peers. One resident made three separate complaints in May of this year. There was another similar complaint in early June regarding a resident being unhappy with living with their current peers. On review of the complaints the inspector found that the complaints had been submitted to the complaints officer but the documentation of how complaints were being managed and if the complainant was satisfied was unclear. This was discussed with the residential and respite coordinator who identified that a new system was due to be introduced that would address these issues.

Judgment: Substantially compliant

Quality and safety

In general, the quality and safety of care provided to the residents was to a good standard and their health, emotional and social care needs were being assessed. However, the emergency temporary placement that the residents were residing in and the compatibility of the residents was impacting on the provider's ability to provide a quality service.

The person in charge had ensured that assessments had taken place in relation to the health, personal and social care needs of the residents. Inspectors viewed a sample of residents' individualised plans and found them to de detailed with headings including social skills, health needs and behaviours that concerns. There was evidence that the care plans were being audited with the last updates for some plans taking place in April of this year. The inspector found that the provider had adapted a day service program to meet the needs of one of the resident and that this had led to positive outcomes for the resident.

The person in charge had insured that the residents had access to a range of healthcare professionals. On review of a sample of the resident's appointment logs, the inspector saw that residents were attending appointments with allied healthcare professionals including general practitioners, physiotherapist and dietician when required.

Inspectors observed documentation where a resident had refused to attend a medical treatment. This decision was respected by the staff team and the resident's medical practitioner was contacted and an alternative approach that better suited the resident was chosen. This led to the resident partaking in the medical treatment.

Inspectors reviewed a sample of the residents person centred plans. These plans were developed in conjunction with the residents and were being utilised to support the residents to achieve their chosen goals. The inspector viewed key working reports and plans that showed how goals were being set, planned for and achieved. Goals that had been achieved included planning for a birthday party and attending social outings such as attending a nightclub with the support of a staff member. The inspector also viewed goals for the coming months and plans were in place on how to support their achievement.

The provider had completed compatibility and suitability assessments for the residents. The outcome from these assessments was that the mix of residents in the centre was not suitable due to the impact they have had on one another. The provider had also identified that the emergency temporary accommodation in the centre was not suitable for one resident due to the centres size and the resident's diagnosis. The provider, as a result, did not have arrangements to meet the needs of each resident and had not ensured that the designated centre was suitable for the purpose of meeting the needs of each resident.

The person in charge had ensured that the staff team had received training in the management of behaviour that is challenging including de-escalation and intervention techniques. The inspector reviewed behaviours of concern plans for a sample of the residents. Parts of these plans were detailed and it was evident that they were under review. However, one resident's behaviours of concern plan had

been in review since January 2019 and had yet to be finalised. A reactive strategies plan had been introduced during this review but there was need for a more detailed response to support the resident around their behaviours of concern. The inspector observed another behaviour assessment plan that had not been reviewed since 2017. There was evidence that work had been completed since then but a complete assessment had not taken place. The systems for reviewing behaviour support plans required improvement.

Further behaviour support assessments reviewed by the inspector identified that for one resident, the lack of access to a behaviour therapist had the potential to directly impact upon the delivery of effective services for the resident. The provider has identified the need for this therapeutic intervention but had not yet filled the post. The provider and person in charge were actively working to support the residents, however, the lack of intervention meant that the person in charge was unable to identify and alleviate the cause of the resident's challenging behaviour.

The inspector reviewed the restrictive practice log that was in place for the centre. There were some restrictive practices in place including the front door being locked. This practice has been implemented for one resident. The impact has however been limited as other residents have their own keys to the door. The person in charge was considering alternative measures before a restrictive practice was used and that the centre was seeking to implement the least restrictive practice, where possible. There was also evidence of the restrictive practices being reviewed by members of the provider's multi-disciplinary team.

The inspector observed that the person in charge had initiated and carried out investigations in relation to incidents of actual, alleged or where there had been suspicions of abuse towards residents. The person in charge had developed safeguarding plans for residents that were under regular review and the inspector noted that the staff members had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. The inspector reviewed the safeguarding measures in place with one member of staff who was competent in discussing same and the steps to take following an allegation being made.

The compatibility issues present in the centre were, however, impacting on the provider's ability to effectively safeguard all residents and reduce challenging peer to peer interactions. The provider had raised this concern and was actively seeking to source alternative accommodation in an attempt to reduce the negative impact on the residents. This matter has been actioned separately under regulation 5.

The provider had ensured that financial management plans had been carried out for the residents to ensure residents' property was safeguarded. Residents' capacity to manage their own financial affairs had been assessed and it was found that all residents required some level of support. Regular audits of the residents' finances were taking place by the provider. Daily checks were also being carried out by the staff team. The person in charge had also created and maintained a personal possessions list for each resident.

There was evidence that the person in charge and staff team were seeking to promote the rights of the residents'. The residents person centred plans displayed that the provider was ensuring that the residents, when, possible were participating in and leading the development of their care and support. There were regular residents' meetings taking place, where residents were provided with educational information on topics including staying safe from abuse and also how to make complaints. The inspector observed recent minutes which showed how a resident was supported around deciding to purchase a tablet device. The resident was provided with information regarding costing in an appropriate manner and a plan was put in place to purchase the device. It was clear form the centres complaints log that residents were being supported with their right to complain.

The provider had ensured that the risk management policy met the requirements set out in the regulations. There were systems in place that sought to manage and mitigate risks and keep residents and staff members safe in the centre. There was a risk register specific to the centre that was reviewed regularly that addressed social and environmental risks. The provider had ensured that restrictive practices in the centre had been risk rated and that the impact of these practices on the residents had been considered. The inspector observed that a risk assessment had been completed regarding the incompatibility of the residents residing in the centre and that it had received a high risk rating.

The provider had ensured systems were in place to ensure the prevention of fire, and the safe management of any emergency. There was appropriate fire safety equipment available, and fire doors throughout the centre. Each resident had a personal emergency evacuation plan which outlined the support needs in case of an evacuation. The appropriate servicing and maintenance of equipment had taken place, and regular fire safety checks were undertaken and documented. While fire drills had been conducted in the centre these had not included all of the residents at one time and with the lowest number of staff members, therefore the provider could not be assured that all residents could be evacuated in a timely manner in the event of an emergency.

The person in charge had ensured that the centre had appropriate and suitable practices in relation to the ordering, receipt, prescribing, storing, disposal and administration of medicines. There was also evidence that staff members working in the centre had received adequate training to administer medication safely. The inspector reviewed the storing, disposal and returning of medication with a member of the staff team, who was competent in explaining the practices, carried out regarding same. The inspector also viewed that the person in charge had ensured that the capacity of residents to take responsibility for their own medication had been assessed.

Regulation 10: Communication

The provider had ensured that each resident was assisted and supported to communicate in accordance their needs and wishes.

Judgment: Compliant

Regulation 12: Personal possessions

The provider had ensured that financial management plans had been carried out for the residents. Residents capacity to manage their own financial affairs had been assessed and it was found that all residents required some level of support.

The person in charge had also created and maintained a personal possessions list for each resident.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured that the risk management policy met the requirements set out in the regulations. There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured systems were in place to ensure the prevention of fire, and that plans were in place for the management of potential emergencies.

While fire drills had been conducted in the centre they had not included all of the residents at one time and with the lowest number of staff members on duty, therefore the provider could not be assured that all residents could be evacuated in a timely manner in the event of an emergency.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had ensured that the centre had appropriate and suitable practices in relation to the ordering, receipt, prescribing, storing, disposal and administration of medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that assessments had taken place in relation to the health, personal and social care needs of the residents. The inspector reviewed a sample of the residents person centred plans. These plans were developed in conjunction with the residents and were being utilised to support the residents to achieve their chosen goals.

However, the provider had identified that the centre was not suitable to meet the needs of the current grouping of residents.

Judgment: Not compliant

Regulation 6: Health care

It was found that the residents' healthcare needs were being supported in a proactive manner with evidence of regular check-ups and the provider supporting the residents' to access appropriate services.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had ensured that the staff team had received training in the management of behaviour that challenges including de-escalation and intervention techniques.

The inspector reviewed the restrictive practice log that was in place for the centre. There was evidence that the person in charge was considering alternative measures before a restrictive practice were used and that the centre was seeking to implement the least restrictive practice where possible. There was also evidence of

the restrictive practices being reviewed by members of the provider's multi-disciplinary team.

The provider had identified that therapeutic interventions were required to support a resident with their behaviours. The provider had, however, been unsuccessful in sourcing this intervention. Some behavioural support plans were not up to date.

Judgment: Substantially compliant

Regulation 8: Protection

The provider was seeking to adequately safeguard residents in the centre and where required, safeguarding plans were in place.

Judgment: Compliant

Regulation 9: Residents' rights

A review of the residents person centred plans displayed that the provider was ensuring that the residents, when possible, were participating in and leading the development of their care and support. There were regular residents' meetings taking place, where residents were provided with educational information on topics including staying safe from abuse and also how to make complaints.

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
Views of people who use the service	
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	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Adult Respite Service OSV-0001841

Inspection ID: MON-0023768

Date of inspection: 12/06/2019

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Alternative accommodation services have been identified with each resident and their natural support which will led to the development of individual transition plans over the coming weeks. • Compatibility and suitability assessments conducted in consultation with each resident and their natural support will be revised in terms of each resident's physical and social environmental needs. • Transition plans will be discussed at all team meetings commencing July 2019.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: • Enhancement of current system will allow for electronic logging of complaints and will be rolled out across the service on the 1st August 2019. • PIC will ensure all staff are familiar with new system. • New complaints policy and procedure will be discussed at upcoming team meetings in July and August 2019.	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • Fire drill will be organised with all four residents at one time, supported by minimum number of staff on duty, before 31st July 2019. • PIC will ensure to review fire drill schedule to ensure where possible all four residents are in the centre at the time of fire drill and evacuation. • Copy of monthly fire drill will be sent to the residential coordinator for review. • Fire safety along with findings and recommendations from this report will be discussed at upcoming team meetings in July and August 2019.	
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: • Alternative accommodation services have been identified with each resident and their natural support which will led to the development of individual transition plans over the coming weeks. • Compatibility and suitability assessments conducted in consultation with each resident and their natural support will be revised in terms of each resident's physical and social environmental needs. • Transition plans will be discussed at all team meetings commencing July 2019.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Assistive technology required for intervention referred to in the report has been purchased by St. Christopher's services. • Progress following it's implementation will be monitored and recorded by staff team with oversight from PIC and Clinical Psychologist. • All behavior support plans in place in the centre were reviewed by Clinical Psychology on 17th June. • Interviews for behavior specialist have been held and the position will be filled by 31.08.2019	

- The above actions will be communicated at July team meeting.
- Assistive technology will be reviewed regularly and at August team meeting.

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 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	31/10/2019
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.	Substantially Compliant	Yellow	31/08/2019
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	31/08/2019

Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/10/2019
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/10/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	31/08/2019