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:	Ballymun Road
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	22 – 23 January 2019
Centre ID:	OSV-0002379
Fieldwork ID:	MON-0021674

About the designated centre

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

The designated centre is based in a suburban area of North Dublin and is comprised of one semi-detached two storey building. There are two resident bedrooms on the ground floor of the centre along with an entrance hallway, a kitchen and dining space, a living room, a sensory or music room, a utility room, a large wheelchair accessible bathroom, and a separate toilet with wash hand basin. On the first floor there are four resident bedrooms, a staff sleep over room, a main bathroom, and an additional separate smaller toilet and hand basin. There is a driveway to the front of the property with a garden to the rear with shed and outdoor dining space. There is a person in charge employed in the centre and a staff team of social care workers and a staff nurse.

The following information outlines some additional data on this centre.

Current registration end date:	19/05/2019
Number of residents on the date of inspection:	6

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
22 January 2019	10:00hrs to 18:00hrs	Thomas Hogan	Lead
23 January 2019	09:20hrs to 15:30hrs	Thomas Hogan	Lead

Views of people who use the service

The inspector met with five residents availing of the services of the designated centre and spent time observing the care and support being delivered by staff members. In addition, the inspector spoke with a family member of a resident via telephone. Six completed questionnaires were made available to the inspector which captured responses to a range of areas including satisfaction with the service, accommodation, food and mealtime experience, visitor arrangements, residents' rights, activities, care and support experience, staff, and complaints. Feedback provided by respondents was very positive and outlined high levels of satisfaction with the services provided in the centre.

Capacity and capability

The inspector found that overall there were mixed levels of compliance with the regulations inspected against. Care and support being delivered to residents was observed to be timely and respectful and the inspector found that there was clear evidence of a person-centred culture in the centre. There were; however, a number of areas of non-compliance identified through the inspection process. The inspector found that the governance and oversight of the centre required improvement and arrangements to ensure that notifications were made to the Office of the Chief Inspector as required by the Regulations required strengthening.

A review of staffing arrangements found that there was an appropriate skill mix amongst the staff team employed in the centre. There was a minor deficit observed in the numbers of staff members employed which had an impact on the supports available to residents while attending social activities on a number of evenings each week. Staff duty rosters were found not to have been maintained to a satisfactory level in the centre. Planned and actual rosters were not maintained and rosters were not labelled as such. While there was one long term staff vacancy at the time of inspection, the person in charge outlined that there was a recruitment campaign underway to fill this post. The inspector reviewed a sample of three staff files and found that all documents required by Schedule 2 of the Regulations were present and satisfactorily maintained. The inspector reviewed staff training records and found that a number of staff members had not completed training or refresher training in a number of mandatory areas as outlined by the centre's policies and procedures.

While there were systems in place in the centre for both the formal and informal supervision of staff members, the inspector found that one-to-one supervision meetings were not held with staff members as frequently as required by

organisational policy. In the case of four staff files reviewed, none were found to have had one-to-one supervision meetings on six occasions in 12 months as required.

Governance and management arrangements in place in the centre were reviewed by the inspector. While there were clearly defined management structures in place, the inspector found that there was an absence of appropriate governance and oversight in the centre. Audits, unannounced visits, and annual reviews completed failed to identify and recognise key risks and areas of non-compliance with the regulations. For example, in the annual reviews completed for 2016 and 2017, the authors failed to identify key concerns such as fire safety, risk management, safeguarding and protection, staff training, and other areas which required improvement and development. In an unannounced visit to the centre (dated 15 January 2019) the registered provider's report stated that there were no outstanding issues to be addressed relating to an 'accident and incident review'; however, the inspector identified poor follow up to a number of incidents which had occurred.

The inspector reviewed the centre's statement of purpose (dated November 2018) and found that a number of areas of this document did not meet the requirements of the Regulations. Following the inspection, a revised statement of purpose (dated March 2019) was forwarded to the inspector and it was found that this document contained all required information.

A review of incident, accident and near miss records maintained in the centre found that a number of incidents which had occurred were not notified to the Office of the Chief Inspector as required by the Regulations. Three alleged safeguarding incidents had not been notified by the person in charge within three working days of their occurrence.

The inspector found that there were appropriate systems in place in the centre for managing and responding to complaints. The person in charge maintained records of all complaints and these were made available to the inspector. All five complaints recorded for 2018 and 2019 were found to have been appropriately followed up on and closed off. Complainants were informed of the outcome of the complaints process in all cases. There was a complaints policy and procedures in place and these were on display in an easy read format. Contact information for advocacy support services and a confidential recipient were also on display.

A review of policies and procedures maintained in the designated centre was completed by the inspector. A number of policies were found not to have been reviewed as required within a three year time period or within the review dates specified on the documents. In addition, the inspector found that the policy in place in the centre relating to residents' property, personal finances and possessions did not provide any direction or guidance on the matter of residents' property. A policy relating to the recruitment, selection and vetting of staff was found not to be in place in the centre.

Regulation 15: Staffing

There was a minor deficit observed in the numbers of staff members employed in the centre and as a result residents' needs were not being fully met. Staff duty rosters were found not to have been maintained to a satisfactory standard in the centre. Planned and actual rosters were not maintained and rosters were not labelled as such.

Judgment: Substantially compliant

Regulation 22: Insurance

The centre was found to have been insured against accidents or injury to residents.

Judgment: Compliant

Regulation 3: Statement of purpose

A revised statement of purpose submitted to the inspector following the inspection was found to contain all necessary information.

Judgment: Compliant

Regulation 31: Notification of incidents

Three alleged safeguarding incidents which had occurred were not notified to the Office of the Chief Inspector as required by the Regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The inspector found that there were appropriate systems in place in the centre for managing and responding to complaints.

Judgment: Compliant

Regulation 4: Written policies and procedures

A number of policies were found not to have been reviewed as required within a three year time period or within the review dates specified on the documents. These were:

- the policy relating to the provision of behavioural support;
- the policy relating to the use of restrictive procedures and physical, chemical and environmental restraint; and
- the policy relating to the creation of, access to, retention of, maintenance of and destruction of records.

In addition, the inspector found that the policy in place in the centre relating to residents' property, personal finances and possessions did not provide any direction or guidance on the matter of residents' property. A policy relating to the recruitment, selection and vetting of staff was found not to be in place in the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector reviewed staff training records and found that a number of staff members had not completed training or refresher training in a number of mandatory areas as outlined by the centre's policies and procedures. These were as follows:

- two staff members had not completed training or refresher training in safeguarding vulnerable persons;
- three staff members had not completed training or refresher training in children first;
- three staff members had not completed training or refresher training in fire safety;
- three staff members had not completed training or refresher training in hand hygiene; and
- two staff members had not completed training or refresher training in food safety.

One-to-one supervision meetings were not held with staff members as frequently as required by organisational policy.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector found that there was an absence of appropriate governance and oversight in the centre. Audits, unannounced visits, and annual reviews completed failed to identify and recognise key risks and areas of non-compliance with the regulations. There were no arrangements in place for the performance management of members of the workforce.

Judgment: Not compliant

Quality and safety

The inspector found that there were clear examples to demonstrate that residents were supported to live active and meaningful lives and were in receipt of person-centred care through services provided in the centre. Residents were supported to develop and maintain relationships and links with their local communities and resided in a comfortable and homely environment. However, there were a number of areas of non-compliances identified though the inspection process. Ares of non-compliance related to risk management, fire safety, medication management, assessments and personal planning, and safeguarding. The inspector found that improvements were required in these areas to ensure that the care and support being delivered to residents was safe and of a good standard.

The inspector found that residents were supported through accessible, tailored and inclusive methods of communication employed in the centre. Staff members demonstrated detailed knowledge of residents' communication needs and had participated in training to provide supports to residents in this area. For example, staff members had completed training in 'lámh' communication and were observed by the inspector using this to communicate with residents. There were also support systems in use in the centre for picture references, objects of reference, and picture exchange programmes. There was internet access available for residents via wi-fi throughout the centre and there were televisions, computers, electronic tablets also available. Some residents were availing of assistive technology through applications installed on electronic tablets to promote and develop skills in the area of emotional well being.

The general welfare and development of residents was reviewed by the inspector and it was found that residents were supported to experience meaningful and active lives in their local community. Residents attended a variety of day services in the area and availed of a wide range of social clubs and activities at weekends and evening times. There was clear evidence available to demonstrate a person-centred approach to the provision of services and opportunities for recreation and social activities. In a one month period reviewed by the inspector, it was noted that

residents attended a significant number of clubs and activities such as drama, art, bowling, cinema, friendship groups, drum classes, pantomimes, and musicals. Residents were also supported and encouraged to develop and maintain relationships with their natural networks and the wider local community. One resident was supported to volunteer in a local church, while other residents were found to use local services such as hairdressers, supermarket and post offices on a regular basis and had developed acquaintances and friendships with neighbours.

The centre was observed to be clean throughout and appeared to be of sound construction. A few minor areas were observed to require painting and decorating such as a bedroom and an area of the entrance hallway. All residents were found to have their own individual bedrooms and these were decorated in line with residents' personal tasted and preferences. There were adequate private and communal spaces provided in the centre and sufficient numbers of bathrooms, showers and toilets.

The inspector found that a risk management policy (dated April 2016) in place in the centre did not contain all required information as set out in the Regulations. A risk register maintained in the centre was reviewed by the inspector. While a number of risks related to the centre and to residents were listed, the inspector found that all risks had not been identified and assessed. For example, a risk assessment was found not to have been completed on the risks associated with the absence of appropriate fire containment measures and emergency lighting in the centre. Where risks were found to have been identified and assessed, the inspector noted that all risks were rated as "low" despite the absence of appropriate control measures in some instances.

The inspector completed a review of incident, accident and near miss records for the period since the last inspection. It was found that appropriate incident analysis was not taking place and that in some cases, satisfactory follow-up actions were not taken in response to incidents. The inspector found that the occurrence of incident, accidents and near misses were not considered in a risk management context during reviews of the risk register on a quarterly basis.

A review of fire safety measures found that emergency lighting was not in place in four areas of the centre which formed emergency fire exit routes. The inspector also found that satisfactory arrangements were not in place in the centre for the containment of fire.

Records were available to demonstrate that fire extinguishers, emergency lighting, and the fire alarm and detection system were serviced on a regular basis and in line with the frequency required by organisational policy. Personal emergency evacuation procedures (PEEPs) were sampled for three residents and it was found that overall these clearly communicated how residents were to be supported in the event of a fire or emergency. However, in the case of one resident the supports required in the event of a night time evacuation were not included in the PEEP document.

A review of medication storage arrangements found that all medications were appropriate and safely stored in the centre. The inspector observed that in the case

of one resident medication prescribed had not been signed as having been administered on one occasion on the day of the inspection. Blister packed medications were used for four residents and these were found to have no expiry dates available. All other medications had expiry dates listed. In the case of some PRN medications (medications administered as the need arises), the inspector found that the criteria for administration and maximum doses to be administered in a 24 hour period were not clearly listed. Staff members spoken with by the inspector were very knowledgeable of what actions to take in the event of a medication error. The person in charge confirmed that assessments for the self-administration of medication had been completed for only one of the six residents availing of the services of the centre.

A sample of residents' files were reviewed by the inspector and it was found that an assessment of need was completed in all cases. While the document covered a wide range of areas, it was not clear what needs were identified through the completion of the assessment. In the case of one resident, the inspector found that some needs identified through the document did not have corresponding personal plans in place to outline how the resident would be supported. For example, despite areas such as "needs support with written information", and "is interested in learning something new" being selected by the assessor, these were not addressed in any area of the resident's personal plan. The inspector found that there were a significant number of personal plans in place for residents; however, these were vague in nature and did not, in some cases, outline to the reader how the resident was to be supported with a specific need. There were no objectives or goals listed in many of the personal plans and the specific needs were often not outlined. There was a review mechanism in place for the assessment and personal planning process; however, personal plans were not specifically reviewed for their effectiveness as part of this procedure. Personal plans were not made available to residents in an easy read format as required by the Regulations.

The inspector found that there were appropriate supports in place to address residents' needs relating to behaviours which challenge. Staff members had completed specific training in this area and were knowledgeable of the supports required by residents. The person in charge maintained a log of restrictive practices used in the centre and provided evidence of oversight of the use of these restrictions by a 'Positive Approached Monitoring Group'. Restrictions in use were reviewed at least on an annual basis.

The inspector found a small number of safeguarding incidents that were not followed up on in accordance with national and organisational policy. Furthermore the inspector was not assured that the registered provider was fully protecting and supporting residents to develop the knowledge, self-awareness, understanding and skills required for self-care and protection. Staff members spoken with demonstrated satisfactory knowledge of how to safeguard residents and what actions to take should they have concerns.

Regulation 10: Communication

The inspector found that residents were supported through accessible, tailored and inclusive methods of communication employed in the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were found to have been supported to experience meaningful and active lives in their local community.

Judgment: Compliant

Regulation 17: Premises

The inspector found that some minor areas of the centre required painting and decorating.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The risk management policy in place in the centre was found not to contain two required areas as outlined in the Regulations. The policy did not outline:

- the arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents or
- the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measured might have on the residents' quality of life have been considered.

All risks present in the centre were not identified and assessed. The inspector was not assured that all risks which had been identified were appropriately risk rated. Appropriate follow up was found not to have taken place in the case of all incidents which had occurred in the centre. The quarterly review of the centre's risk register did not include the analysis of incidents, accidents and near misses.

Judgment: Not compliant

Regulation 28: Fire precautions

Some areas of the centre were found not to have emergency lighting as required. Satisfactory arrangements were not in place for the containment of fire. A PEEP document for one resident did not outline the actions to take for a night time evacuation.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Blister packed medications were used for four residents and these were found to have no expiry dates available. The inspector observed that medication for one resident had not been signed as having been administered on one occasion on the day of the inspection. In the case of some PRN medications, the inspector found that the criteria for administration and maximum doses to be administered in a 24 hour period were not clearly listed. The person in charge confirmed that assessments for the self-administration of medication had been completed for only one of the six residents availing of the services of the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector found that it was not clear what needs were identified through the completion of the assessment of need. Some needs identified through the document did not have corresponding personal plans in place. While there were a significant number of personal plans in place for residents, these were vague in nature and did not, in some cases, outline how the resident was to be supported with a specific need. There were no objectives or goals listed in many of the personal plans and the specific needs were often not included. Personal plans were not specifically reviewed for their effectiveness as part of this "annual review" process. Personal plans were not made available to residents in an easy read format as required by the Regulations.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspector found that there were appropriate supports in place to address residents' needs relating to behaviours which challenge.

Judgment: Compliant

Regulation 8: Protection

A small number of safeguarding incidents were not managed or followed up on as outlined in organisational and national policy. The inspector was not assured that the registered provider was fully protecting and supporting residents to develop the knowledge, self-awareness, understanding and skills required for self-care and protection.

Judgment: Not 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 15: Staffing	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ballymun Road OSV-0002379

Inspection ID: MON-0021674

Date of inspection: 22 - 23/01/2019

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: In response to the area of non-compliance found under Regulation 15(1) • A roster review will be completed for the centre and the Registered Provider will ensure the provision of consistent staffing with suitably qualified staff for the centre will be in place in meeting the needs of the residents. In response to the area of non-compliance found under Regulation 15(4) • Going forward the PIC will ensure that rosters are labelled planned and actual	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: In response to the area of non-compliance found under Regulation 31(1)(f) • The PIC will ensure any alleged, suspected or confirmed incidents of abuse will be notified to the authority as NF06 within the agreed timeframe • The PIC and Service Manager will report all incidents of safeguarding to the Principle Social Worker for preliminary screening. • The PIC will further ensure that all such incidents are brought to the attention of the Designated Officer and \ or her delegates, and notified to the HSE for preliminary screening as required.	

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
In response to the area of non-compliance found under Regulation 4 (1)

• The Provider is currently revising and updating the policy relating to the provision of positive behavioural support.

• The Provider is currently revising and updating the policy relating to the use of restrictive procedures and, and physical, chemical and environmental restraint.

• The Provider will update the policy relating to the creation of, access to, retention of, and the maintenance and destruction of records, to reflect the new GDPR legislation.

• The Provider will update the policy relating to the recruitment, selection and vetting of staff. The Provider currently utilises the HSE Garda vetting policy, which applies to all section 38 agencies.

In response to the area of non-compliance found under Regulation 04 (3)

The Provider will review and update all schedule 5 policies in line with Regulation 04(1) and 04(3)

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
In response to the area of non-compliance found under Regulation 16 (1) (a)

• The staff members identified during the inspection are currently being prioritized for the required refresher training by the training department.

In response to the area of non-compliance found under Regulation 16 (1) (b)

• The Person in Charge will complete a schedule of supervision meetings with the staff team in the centre in line with the revised and updated organisations Staff Supervision and Support Policy

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The compliance plan response from the registered provider did not adequately assure the Office of the Chief Inspector that the actions will result in compliance with the regulations.

In response to the area of non-compliance found under Regulation 23(1)(c)

• The Registered Provider will ensure that all future audits, unannounced visits, and annual reviews will identify any key risks and areas of non-compliance within the centre, and will outline a plan of action to address any such deficits.

In response to the area of non-compliance found under Regulation 23(3)(a)

• The Registered Provider will ensure that Supervision and Support meetings will take place 4 time per year for each staff member in the centre. The structures in place within this policy allow for all PICs to provide support and to identify development opportunities for all of their team specifically in relation to their roles and the services they provide. The policy also is designed to identify performance related concerns that will be addressed.

• Pending the agreement and implementation of a national Performance Achievement Scheme, the St. Michael's House Supervision and Support policy provides a robust framework to ensure the organisation is compliant in this regard.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
In response to the area of non-compliance found under Regulation 17(1)(c)

• The PIC has requested that the identified bedroom and areas in hallway be repainted and suitably decorated.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In response to the area of non-compliance found under Regulation 26(1)(d)

• The Provider will update the Risk Management policy to address the arrangements for the identification, recording, investigation of and learning from serious incidents or adverse events involving residents.

In response to the area of non-compliance found under Regulation 26(1)(e)

• The Provider will update the Risk Management policy to address the arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the residents quality of life have been

considered.

In response to the area of non-compliance found under Regulation 26(2)

• A full review of all designated centre risks and proportionate risk allocation will be completed with the PIC, Service Manager and the Health and Safety officer.

• The PIC is trained in the management of risk and in consultation with the service manager and the health and safety officer they will develop systems in the centre for the assessment, managements and ongoing review of risk, which include a system for responding to emergencies.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The compliance plan response from the registered provider did not adequately assure the Office of the Chief Inspector that the actions will result in compliance with the regulations.

In response to the area of non-compliance found under Regulation 28(2)(b)(ii)

• In line with Regulation 28(2)(b)(ii), all personal evacuation plans will be reviewed at least annually or sooner in the event of changing need

• The PIC has incorporated the night time evacuation support plan in place for one resident into the Personal evacuation plan.

In response to the area of non-compliance found under Regulation 28(2)(c)

• The PIC has requested, and has received assurances that, emergency lighting will be installed in the dining room, sitting room, music room and utility room.

In response to the area of non-compliance found under Regulation 28(3)(a)

• The Registered provider has ensured that comprehensive arrangements are in place for the detection, and containment and extinguishing of fire.

In response to the area of non-compliance found under Regulation 28(3)(d)

• The Registered Provider has made adequate arrangements for the evacuation of all residents, where necessary in the event of a fire, and transporting them to a safe location.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
In response to the area of non-compliance found under Regulation 29(4)(b)

• The PIC will obtain a letter from the medication supplier which states that the blister packs supplied to the designated centre weekly has a minimum expiry date of 3 months from the date the centre receives them.

• The Person in Charge will review the centre's systems for the recording and auditing of medication, to ensure that they comply with the Provider's policies and procedures.

• The PIC has taken steps to ensure that the criteria for administration and maximum doses of PRN medication in a 24 Hr period are clearly listed.

In response to the area of non-compliance found under Regulation 29(5)

• The PIC has completed assessments for self administration of medications with all residents in the Centre.

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:
In response to the area of non-compliance found under Regulation 05(1)(b)

• The Assessments of Need will be reviewed by the PIC and Service Manager to ensure that all identified support needs, have corresponding support plans, which clearly outline the support requirements, and the steps in place to assist the resident in each plan.

In response to the area of non-compliance found under Regulation 05(02)

• The Registered Provider will ensure that arrangements are in place to meet the needs of each resident through appropriate health care professional support in meeting residents health, personal and social care needs

In response to the area of non-compliance found under Regulation 05(4)(a)

• The Person in Charge will ensure that a comprehensive assessment of each residents' needs is completed and reviewed with the support of allied health care professional as required
In response to the area of non-compliance found under Regulation 05(4)(b)
• Each resident assessment of need and support plans will be reviewed and update by residents key workers as required in line with the residents personal development and wishes and clearly outlying how each individual residents is to be supported with their specific need
In response to the area of non-compliance found under Regulation 05(5)

• Goals identified as important to the residents will be recorded and monitored in the All About Me documentation and will be tracked through monthly reports, key worker audits and annually at the Outcome review meeting. The PIC will ensure all residents will be consulted with the levels of accessibility for their Personal Plans.

In response to the area of non-compliance found under Regulation 05(6)(c)

• All support plans will be reviewed for their effectiveness at the annual outcome review or as required

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
In response to the area of non-compliance found under Regulation 08(1)

• The PIC has a system in place whereby weekly meetings are held with the residents in the Centre, to discuss the plans for the week ahead. As a part of those meetings, residents are reminded of the process for making a complaint, and of the steps to follow in the event of their being upset or unhappy with an interaction between themselves and any other person. This includes staff members, fellow residents, or any other person with whom they come into contact.

In response to the area of non-compliance found under Regulation 08(2)

• The PIC and the Provider will ensure that all safeguarding incidents are managed and investigated as outlined by the Organisational and National policies, and that procedures are in place to protect residents from all forms of abuse, as required by regulation 08(2).

In response to the area of non-compliance found under Regulation 08(3)

• The PIC and Provider will ensure that all safeguarding incidents are fully investigated, and that appropriate action is taken as per the above-mentioned policies in the event of any abusive interaction, which impacts on any resident\s in the 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	10/05/2019
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	01/05/2019
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	30/06/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises	Substantially Compliant	Yellow	30/08/2019

	of the designated centre are clean and suitably decorated.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2019
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/12/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	31/05/2019
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	31/05/2019

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	30/06/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	21/03/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/06/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	21/03/2019
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.	Not Compliant	Orange	21/03/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	05/04/2019
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity,	Not Compliant	Orange	02/04/2019

	each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	21/03/2019
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.	Not Compliant	Orange	15/12/2019
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 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/06/2019

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	30/06/2019
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/06/2019
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	30/06/2019
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Orange	30/09/2019
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	30/09/2019
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-	Not Compliant	Orange	21/03/2019

	awareness, understanding and skills needed for self-care and protection.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	21/03/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	21/03/2019