Office of the Chief Inspector

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

Name of designated centre:	The Willows
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	04 July 2019
Centre ID:	OSV-0002394
Fieldwork ID:	MON-0022469

About the designated centre

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

The designated centre is located in a suburban area in Dublin city and is operated by St Michael's House. It provides community residential services to seven residents, both male and female, over the age of 18. The designated centre is a two storey house and adjoining apartment. The house accommodates six people and consists of a sitting room, kitchen/dining area, quiet room, a staff sleep over room or office, a bathroom and six individual bedrooms (four of which are en-suite). The apartment accommodates one person and consists of two bedrooms (one of which is en-suite), bathroom and kitchen/living room. The centre is located close to amenities such as shops, cafes and public transport. The centre is staffed by a person in charge, nurses and social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
04 July 2019	09:40hrs to 19:00hrs	Conan O'Hara	Lead
04 July 2019	09:40hrs to 19:00hrs	Amy McGrath	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet with six of the residents living in the designated centre during the course of the inspection. One resident was not in the centre on the day of the inspection. Some residents communicated their thoughts and opinions verbally while others used non verbal methods to communicate. Some residents choose not to engage with inspectors. The inspectors observed care practices and staff interactions with residents over the course of the inspection. In addition, feedback of the service was received through questionnaires completed by the residents and/or their representatives which reviewed matters such as accommodation, food and mealtime experience, visiting arrangements, residents' rights, activities, staffing and complaints.

Overall, residents appeared relaxed in their home and were also seen to be comfortable in the presence of both staff and management. The inspectors observed residents preparing to access the community and take part in activities of preference and interests. Throughout the course of the inspection, positive interactions were observed between residents and staff.

Through the questionnaires, residents expressed levels of satisfaction with the care and support they were in receipt of. However, a number of residents highlighted that improvements could be made to the upkeep of the garden as they like to spend time there. In addition, one questionnaire noted that staff in the centre were kind and caring however, expressed concern in relation to staffing levels.

Capacity and capability

Overall there was clear management systems in place in the centre, however improvements were required in the governance of the service to ensure that the service was consistently and effectively monitored. Improvements were required in governance and management, staffing and training.

There was a defined management structure in place. There was a suitably qualified and experienced person in charge employed in a full-time capacity. The person in charge worked directly with residents and had protected management time of eight hours a week. There were systems in place to monitor and evaluate the quality of care provided to residents such as quality assurance audits which included annual reviews and the six monthly unannounced provider visits. However, the inspectors found that the governance arrangements in place did not facilitate the effective operational management and administration of the designated centre.

The inspectors were informed plans were in place to develop the governance arrangements including a recent change to the service manager and the current recruitment for additional management support role.

The person in charge maintained a planned and actual roster for the centre. The inspector reviewed a sample of rosters which demonstrated that there was a sufficient number of staff to meet the needs of the residents. However, at the time of the inspection, the centre was operating with 1.5 whole time equivalent vacancies. While the provider made efforts to cover vacancies with familiar staff through the use of regular relief and agency staff, this did not ensure continuity of care was maintained at all times. The inspectors acknowledge that the provider was in the process of a recruitment campaign and had completed a roster review which reduced the level of reliance on relief and agency staff since the last inspection.

The inspectors reviewed a sample of staff files and found that most of the information as required by Schedule 2 of the regulations was contained in the staff files. However, one file reviewed did not contain information in relation to correspondence, reports and records of disciplinary action.

There were systems in place for the training and development of the staff team. From a review of the training records, the inspectors found that not all staff had up-to-date mandatory refresher training including fire safety, safeguarding and safe administration of medication. This meant that not all of the staff team had up-to-date training to meet the needs of the residents. The inspectors also reviewed a sample of staff supervision records and found that not all of the staff team were supervised in line with the provider's policy.

Regulation 15: Staffing

There were planned and actual rosters maintained in the centre. There were appropriate staff numbers in place to meet the assessed needs of residents and to provide for the safe delivery of service. However, at the time of the inspection, the centre was operating with 1.5 whole time equivalent vacancies. There was a reliance on agency and relief staff and continuity of care was not maintained at all times.

Not all of the information as required by Schedule 2 of the regulations was contained in one of the staff files reviewed.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff

team. However, not all staff had up-to-date mandatory training in fire safety, safeguarding, safe administration of medication.

Not all of the staff team were supervised in line with the provider's policy.

Judgment: Substantially compliant

Regulation 22: Insurance

The centre had up-to-date insurance in place.

Judgment: Compliant

Regulation 23: Governance and management

There was a defined management structure in place. While, there were systems in place to monitor and evaluate the quality of care provided to residents, the governance arrangements did not ensure effective operational management and administration of the designated centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider maintained a Statement of Purpose dated July 2019. It contained all of the information as required by Schedule 1 of the Regulations. However, some room sizes were not included in the description of the floor plan.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The Office of the Chief Inspector was notified of incidents as required by Regulation 31.

Judgment: Compliant

Quality and safety

Inspectors found, that while there were efforts made to promote person centred care, the governance and staffing arrangements in place in the centre required improvement to ensure the provision of a quality and safe service. Areas for improvement included personal plans, residents rights, medication, personal possessions, safeguarding, premises, fire safety and risk management.

The inspectors completed a walk-through of the centre and found that the house was homely and well maintained. The designated centre is a two storey house and adjoining apartment. The house accommodates six people and consists of a sitting room, kitchen/dining area, quiet room, a staff sleep over room or office, a bathroom and six individual bedrooms (four of which are en-suite). The apartment accommodates one person and consists of two bedrooms (one of which is en-suite), bathroom and kitchen/living room. Some residents noted in their questionnaires that the garden required some upkeep to make it more welcoming. A number of issues with the premises had been identified and the provider had a schedule of works in place to address areas which required attention including the painting of the centre.

The inspectors reviewed a sample of residents' personal files and found that an up-to-date assessment of need had been completed for each resident. The assessment of need identified residents' health and social care needs and informed residents' personal support plans. However, some personal plans in place were not up-to-date or regularly reviewed. In addition, some personal plans reviewed did not appropriately guide the staff team as they contained inaccurate information. This meant that the personal plans in place did not effectively ensure that residents' health and social care needs were being provided for and were inadequate in guiding staff on how to meet residents assessed needs.

Residents had access to a General Practitioner and a range of allied health professionals as appropriate. There was evidence that the provider responded effectively to health-care concerns. However, some heath-care plans reviewed contained conflicting information to the allied health professionals reports. For example, a feeding, eating and drinking health-care plan stated a resident was independent at meal times while the speech and language assessment stated the resident needed to be supervised. This issue is referred to under Regulation 5: Individual Assessment and Personal Plans.

There were positive behavioural supports in place for residents as required. A review of plans found these support plans were up-to-date and guided the staff team in supporting residents manage their behaviour. The inspectors reviewed a sample of restrictive practices in place and found that these were subject to review by a monitoring group, risk assessed and reviewed regularly for effectiveness. The issues identified in relation to the use of a restrictive practice at the last inspection had

been addressed by the provider.

While it was observed that the provider had considered residents rights in relation to restrictive practices, inspectors found that there was improvement required to ensure that residents rights were consistently promoted and upheld on a day-to-day basis. Inspectors found that some practices in the centre did not facilitate residents to participate in and consent to decisions about their care. For example, there were were some daily practices in relation to care and support that represented a restriction of a residents right to exercise choice and control in their daily lives, such set days when a resident could consume alcohol. While the person in charge was knowledgeable of the rationale behind some of these practices, improvement was required to ensure residents participated in and consented to decisions about their care, and that restrictions in relation to this were recognised and addressed.

The inspectors also found that there were limitations in relation to how residents could spend their own money, including restrictions on methods of purchasing items. Inspectors found that in certain cases a member of staff was required to 'authorise' purchases by residents. It was not evident that the residents own will and preference was considered sufficient ground for spending their own money.

There were systems in place to safeguard residents. Of the staff spoken with by the inspectors, they were clear in what constituted abuse and what to do in the event of an allegation or concern. The inspectors observed residents appearing comfortable and relaxed in the presence of staff and management and positive interactions were observed between staff and residents over the course of the inspection.
However, there was improvement required regarding the recognition of potential abuse. While the provider had recognised some situations that could potentially impact residents safety, others had not been identified. For example, the provider had carried out an audit of residents finances, and noted some discrepancies in relation to the management of residents personal finances. While the provider had addressed some of the issues identified at local level, some of the findings of this review were not followed up by the provider to determine if there was a safeguarding concern.

There were arrangements in place for the assessment, management and ongoing review of risk. The provider maintained a risk register which was up-to-date and outlined individual and service risks including staffing vacancies, epilepsy, behaviour and injury. However, some risk assessments required review to ensure they were reflective of the risk and the current controls in place to manage these risks.

There were arrangements in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Personal Emergency Evacuation Plans (PEEP) were in place for each resident. The inspectors found that not all PEEPs appropriately guided staff on the supports for each resident to evacuate the designated centre. This was addressed on the day of the inspection. Centre records demonstrated the fire drills were carried out regularly. However, improvement was required in the review of fire safety precautions. For example, the

last night time fire drill took place in July 2018. This drill identified that one resident did not evacuate and there was no evidence of follow up to ensure the safe evacuation of all people at night time. This had been identified by the provider in the most recent six monthly audit dated July 2019. In addition, the fire safety checklists in place for daily and quarterly checks were not fully completed.

Inspectors reviewed the medication management practices within the centre. There were suitable ordering and storage arrangements in place, and unused or out of date medicines were disposed of in accordance with the providers policy. There were some concerns regarding the practices relating to the administration of medicines to residents. Inspectors found that some records pertaining to the administration of medicines did not contain accurate or sufficient information. For example, the dosage of one medicine was recorded on an administration sheet as 10mg, however the corresponding PRN (medicine to be taken as the need arises) guidance indicated a dose of 5-10mg. Another medicine was recorded in PRN guidance, and an epilepsy care plan, as being prescribed to use as required following seizure activity, despite not being recorded as such on the residents administration sheet.

Inspectors had concerns relating to the recording and response to medication errors. A review of records found that recorded errors had not been followed up with in line with the providers own policy, with a generic response noted on both records reviewed. Inspectors also observed a resident being administered medicine outside of the time indicated; a medicine prescribed to be administered at 2pm was administered at 3.35pm, and was recorded inaccurately as being administered at 2pm. This practice did not support safe administration of medicines to residents, and was particularly concerning as it was a medicine prescribed to be taken multiple times per day.

Regulation 12: Personal possessions

Improvement was required to ensure that residents have access to and retain control of their personal property and finances, with appropriate support provided where necessary.

Judgment: Not compliant

Regulation 17: Premises

The centre was homely and well maintained. A number of issues with the premises had been identified and the provider had a schedule of works in place to address areas which required attention including painting of the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

There were arrangements in place for the assessment, management and ongoing review of risk. Some risk assessments required review to ensure they were reflective of the risk and the current controls in place to manage these risks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were arrangements in place for fire safety management. The centre had suitable fire safety equipment in place including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Centre records demonstrated the fire drills were carried out regularly. However, improvement was required in the review of fire safety precautions.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Residents had access to a pharmacist, and there were suitable practices in place in relation to the ordering, storage, and disposal of medicines. However, the provider had not ensured that there were appropriate practices in place regarding the administration of medicines to residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was an up-to-date assessment of need completed for each resident. The assessment of need identified residents' health and social care needs and informed residents' personal support plans. However, some personal plans in place were not up-to-date or reviewed. In addition, some personal plans reviewed did not appropriately guide the staff team as they contained inaccurate information.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a General Practitioner and a range of allied health professionals as appropriate. There was evidence that the provider responded effectively to health-care concerns.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behavioural supports in place for residents where required. The plans were up-to-date and guided the staff team in supporting residents manage their behaviour. Restrictive practices in place were subject to review by a monitoring group, risk assessed and reviewed regularly for effectiveness.

Judgment: Compliant

Regulation 8: Protection

While there were arrangements in place to protect residents from the risk of abuse, improvement was required to ensure any and all incidents of a potential safeguarding nature were investigated appropriately.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had not ensured that residents participated in and consented to decisions about their care and support, or were given appropriate assistance to support them to make decisions about their daily lives.

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
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for The Willows OSV-0002394

Inspection ID: MON-0022469

Date of inspection: 04/07/2019

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">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 (3)

• The registered provider continues to interview to fill current vacancies. Interviews for staff nurse vacancy have been conducted by the organization at pre-employment stage. Vacancies are subject to pre employment checks by St. Michael's House Human Resource Department
• Position of the Clinical Nurse Manager One advertised and interviews to be carried out on the 12th of September 2019
• PIC continues to complete the roster in a timely manner including regular relief to cover any gaps left by vacancies to ensure a consistent service is provided for all residents in the Willows. The PIC will complete on working actual roster to demonstrate the shifts covered at that time.
• Policy is in place to ensure that a St. Michael's House staff member is on duty at all times within the planned roster

In response to the area of non-compliance found under Regulation 15(5)

• Service Manager has informed HR department of the information received from inspector on the day in relation to check list for staff working frontline and management and review of checklist template completed</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
</table>

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 Person in Charge will continue to ensure that staff have access to appropriate training, including refresher training, as part of continuous professional development programme. Mandatory training is scheduled and planned within the working roster.

• The PIC will continue to liaise with the training department to ensure all staffs training needs are met within the dates outlined going forward.

• Since the inspection all staff are up to date on mandatory training and all new recruits have identified training dates.

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

• The PIC has established a Supervision system for all staff to receive formal support in line with SMH Supervision policy, same will be available in designated centre's diary to assure the supervision and support meetings are completed within the timeframe of 12 weeks, in line with the registered provider's 'Staff's Supervision and Support Policy' .
• The PIC and Service Manager will review supervision at their regular management meetings
• PIC will continue to roster allocated supervision time for staff on the roster ensuring all staff receive adequate support sessions in line with organizational policy.
• PIC will ensure each member of staff member is met as per policy and has set out scheduled time for supervision within management hours.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In response to the area of non-compliance found under Regulation 26 (2)
• Position of the Clinical Nurse Manager One advertised and interviews to be carried out on the 12th of September 2019.
• The Director of Service, Quality Manager, Administration Manager, Service Manager and Person In Charge participate in Monthly Governance and Management meetings for the Willows to assess emerging and on going needs of residents and staff within The Willows
• Director of Nursing, Service Manager, Admin Manager and Person in Charge carry out monthly Nursing review to assess the emerging needs of residents.
• QEP in place and updated to manage and monitor improvements required.
• Management Hours in place for PIC across the roster to ensure adequate governance and support structures for staff and service users.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
In response to the area of non-compliance found under Regulation 03 (1)

• The statement of purpose has been amended to reflect all room sizes on the unit. Document will be submitted with the compliance plan.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
In response to the area of non-compliance found under Regulation 12 (1)

• All residents have personal possessions list in line with organizational policy.
• Services users are supported and offered choice in line with personal preferences identified through past experiences, service users and family involvement when possible. Residents choices in relation to personal possessions will be upheld with additional supports where identified.
• Service Manager and PIC reviewed St. Michael's House policy on Service Users' Monies - Policy and Procedures for the Management of Service Users' Monies by Staff and devised a local policy for The Willows. This policy will ensure that residents have access to their money at all times ensuring greater access to and retain control of their personal property and finances. Services users monies can be used to purchase items of their choice. The PIC and staff team will complete a retrospective review of expenditure to ensure that choice and needs are identified.
• Referral made by PIC and Service manager to the assigned social worker for The Centre to review residents access to finances and personal property.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The Person in Charge, Quality manager and Health and Safety Manager have carried out a review of risk within the designated Centre.
• All risk assessments are in date with identified review dates or sooner if required. All risks and associated control measures have been identified and put in place.
• Up to date risk registered completed post inspection and same is used as a working document to monitor and highlight risk within the centre

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
In response to the area of non-compliance found under Regulation 28(2)(b) (ii)

• The Person in Charge will ensure that fire drills are carried out as per support of residents.
• PEP for each resident has been updated and is in place.
• Night time fire drill carried out 05/08/19.
• The person in charge has added fire safety to all future staff meeting agendas

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 Person in Charge and staff team will continue to ensure that robust medication management including medication audits will be carried out to identify and reduce medication errors and ensure safe practice.
• PRN guidelines amended to reflect MAS
• The Person in Charge has added medication management and drug errors to the agenda of all future staff meetings.
• SAM refresher training has been completed by all staff within The Willows

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(4)(a)

• PIC has scheduled time to review all support plans and assessment of need documents to ensure these are all accurate and updated as appropriate
• PIC has implemented Assessment of Need update within staff supervision process
• Discussed at staff meeting July 2019. PIC has scheduled support sessions and details on roster to discuss assessments of need and support plans with individual support plans.
• Person Centred Planning Coordinator will attend staff meetings 08th of October 2019
• Schedule of review dates in place for each resident for support plans to ensure continuity of care in relation to assessments of needs and to identify emerging needs and address same adequately and in a timely fashion

Regulation 8: Protection	Substantially 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(3)

• The register provider protects all residents from all forms of abuse, All staff have completed training in Safeguarding for adults, this is a fixed item on the staff meeting agenda. Safeguarding refresher is available as required to all staff.
• All staff faithfully follow the safeguarding policy, where there is an allegation or suspicion of abuse all staff will take appropriate action in line with the Safeguarding policy.
• The Register Provider, Clinical and the Person in Charge will investigate in a timely manner and in line with St. Michaels House policy and National Safeguarding policy.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
In response to the area of non-compliance found under Regulation 09(2)(a)
• Weekly residents meetings to be reintroduced and activities planned for the week using pictures to assist residents making choices. Individual residents’ key workers are

completing accessible information for residents incorporating activities and social plans.

- PIC has added weekly meetings to household meeting agendas
- PBS guidelines in line with service users request for alcoholic beverage has been signed by all staff to ensure PBS implemented appropriate
- PBS guidelines in place for one resident around alcohol consumption as resident has a diagnosis of Autism and anxiety and relies on routine and structure reviewed by Psychology department. A trail was carried out in March 2019 to increase the days of alcohol consumption, however this had a significant impact on the residents mental health and anxiety levels. The PBS plan returned to original scheduled days with noted improvements in the Residents mental health and anxiety levels. Yearly review or sooner if required.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/08/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	20/08/2019
Regulation 15(5)	The person in charge shall ensure that he or she has obtained	Substantially Compliant	Yellow	31/10/2019

	in respect of all staff the information and documents specified in Schedule 2.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	16/10/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/09/2019
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	20/08/2019
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	Substantially Compliant	Yellow	16/08/2019

	responding to emergencies.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	26/08/2019
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	20/08/2019
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	20/08/2019
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	Not Compliant	Orange	30/09/2019

	accordance with paragraph (1).			
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.	Substantially Compliant	Yellow	20/08/2019
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	15/08/2019