Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Mulhussey
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	28 January 2020
Centre ID:	OSV-0002967
Fieldwork ID:	MON-0022940

About the designated centre

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

Mulhussey designated centre, operated by St. John of God services is located in the countryside in Co. Meath. It is a six bedroom house, with a capacity for four male and female residents with a moderate/ severe intellectual disability. The property, a two-storey house has two sitting rooms, a dining room, two bathrooms, a large kitchen area and two offices. There is a large garden and grounds for residents to enjoy. There is a purpose built activity building located adjacent to the house. This building is used as a base for the residents to access their community activities and to complete their independent living skills training. Residents are supported on a 24 / 7 basis by a team of social care workers and health care assistants. Access to the community is facilitated by two accessible vehicles.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Tuesday 28 January 2020	09:00hrs to 17:45hrs	Marie Byrne	Lead
Tuesday 28 January 2020	09:00hrs to 17:45hrs	Gearoid Harrahill	Support

What residents told us and what inspectors observed

The inspectors of social services met three of the four residents during the inspection. While residents did not engage in verbal communication, they were happy to show inspectors what they liked about the centre, what their interests were and which staff members they worked with through gesturing and pointing to pictures.

Staff were familiar with residents' communication methods and gestures and were able to engage with residents in a friendly and respectful manner. Residents were comfortable in their house and had a good relationship with the staff and other residents. Staff spoke to inspectors about what residents liked to do with their day and where possible confirmed with residents that what they were saying in their presence was correct.

Through observation and discussions throughout the day, it was evident that residents' choices and preferences were respected in relation to their daily lives. There was evidence that residents were supported to go into the community to run errands and enjoy recreational activity such as swimming and personal shopping. Residents were also encouraged to help around the house with meal preparation and there was a chart in the kitchen listing that residents took turns choosing the dinner each day. Residents' bedrooms were decorated to reflect their preferences and interests, as were their favorite hangout spots in the communal areas of the house.

The provider had captured feedback from all four service users through surveys. Through these, residents expressed that they were happy living in this designated centre and that they were supported to do what they enjoyed in the house and out in the community. Surveys completed by family members also spoke positively on the centre and the support provided to their loved ones.

Capacity and capability

Overall, the inspectors found that the provider and person in charge were monitoring the quality and safety of care and support for residents. They were identifying areas for improvement in line with the findings of this inspection, and putting plans in place to complete the required actions to make these improvements. However, improvements were still required in relation to auditing and monitoring documentation in the centre to ensure it was reflective of residents' needs and clearly guiding staff to carry out their roles and responsibilities. In addition, improvements were required in relation to the maintenance and upkeep of

the premises, fire containment and medication management in the centre.

The provider had submitted an application to renew the registration of the designated centre. All of the required documentation to support this application was not submitted within the required timeframes. The provider had been issued a letter outlining the outstanding documentation and this was also discussed with the provider during the inspection.

This inspection was facilitated by the person in charge. They were found to be knowledgeable in relation to residents' care and support needs and their responsibilities in relation to the regulations. They were motivated to ensure that residents were engaging in meaningful activities in line with their wishes and preferences. They were recognising some of the areas for improvement in the centre in line with findings of this inspection and had plans in place to complete the required actions to make these improvements.

The person in charge was supported in their role by two persons participating in the management of the designated centre (PPIMs). They attended the feedback session at the end of the inspection and outlined systems they had in place to monitor the care and support for residents in the centre. These included; the annual review of care and support, the six monthly visits by the provider and management meetings. These actions from these reviews were included in the quality enhancement plan which identified required actions to make necessary improvements and timeframes for the completion of these required actions. The areas for improvement identified in the providers reviews were in line with the findings of this inspection. However, a number of the required actions had not been completed in relation to the premises and documentation in the centre.

The number and shift patterns of staff was suitable to support the assessed needs of the residents. There was a clear roster which identified the planned and actual staffed hours of care staff, though this document required review to ensure the hours worked by the person in charge were recorded. On the day of inspection there was a vacancy in the staff complement, however inspectors reviewed evidence which indicated that the shifts affected by the vacancy were covered by regular relief staff and as such the impact on continuity of resident support was well managed. The provider was in the process of recruiting to fill this vacancy. Staff in the centre were suitably trained and supervised to ensure they could carry out their duties effectively. In addition to being trained in fire safety, manual handling and safeguarding of vulnerable adults, the provider had also scheduled staff to attend training in caring for people with epilepsy, communication techniques, and positive behavioural support needs. The provider had also identified specialised external training in line with residents needs and advised inspectors that this would be scheduled for staff at the next available opportunity.

Residents were protected by the admissions policies and procedures in the centre. The admissions policy for the centre was also outlined in the centre's statement of purpose. The inspectors reviewed a sample of residents' contracts of care and found that they were in place, signed by the resident or their representative and clearly outlined details of the support, care and welfare to be provided, the services and

facilities provided and the additional fees residents were responsible for. The majority of them clearly outlined the fees to be charged to each resident. However, one residents' contract contained a different figure than what they were actually paying. The inspectors viewed financial records which clearly showed how much the resident was paying. The person in charge outlined that the resident and their representative were aware of the actual fee and stated that they would review and update the contract, and discuss these changes with the resident and their representative.

The inspectors reviewed a sample of incident reports in the centre and found that all incidents which required notification to the Chief Inspector in line with the requirement of the regulations, had been submitted in line with the timeframes identified in the regulations.

Residents were protected by the complaints policy and procedures in the centre. These were available in a format accessible to residents and on display in the centre. This identified the persons responsible for managing and responding to complaints. Records of complaints included details on the issues, the correspondence between the provider and complainant, and the outcome of the matter, including whether the person was satisfied with the resolution. Arrangements were in place for how complaints would be reviewed if the person was not satisfied. The person in charge described the process used in the centre to ensure residents, their representatives and staff were familiar with the complaints procedures.

The inspectors found that whilst improvements had been made in relation to the ease of retrieval of records in the centre, problems remained in relation to accessing hard copy versions of some documents. On a number of occasions, the documents presented to the inspectors were not the most up to date versions. In addition, the accuracy of some records reviewed required improvement. At intervals during the inspection, the inspectors found a number of documents which contained conflicting information and which were not clearly guiding staff in relation to residents' care and support needs. The inspectors requested to view a number of documents in line with resident' assessed needs and although they were in place, they were not easily retrievable. Staff who spoke with the inspectors were knowledgeable in relation to residents' care and support needs. However, some of the documents in place to guide them were not reflective of residents' care and support needs.

Registration Regulation 5: Application for registration or renewal of registration

The provider had not submitted all of the information required by this regulation with the application to renew the registration of the centre within the required timeframes.

Judgment: Not compliant

Regulation 15: Staffing

The number and shift patterns of staff was suitable to support residents. There was a staffing vacancy in the centre but the provider was in the process of recruiting to fill this vacancy and was ensuring continuity for residents in the interim. The staff roster required review to ensure that the hours worked by the person in charge were clearly recorded.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were supported to carry out their roles and were being provided with training to effectively deliver the support needs of the residents. They were in receipt of regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities.

Judgment: Compliant

Regulation 21: Records

Some records in the centre required review to ensure they were reflective of residents' current care and support needs and clearly guiding staff to support them. Improvements were also required to ensure that the most up to date information was available and easily retrievable.

Judgment: Not compliant

Regulation 22: Insurance

Residents were protected by the insurance in place for the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures and clear lines of accountability and responsibility. The provider was monitoring the quality and safety of care and support for residents through their annual and six monthly reviews and identifying areas for improvement. However, they were not completing all of the actions outlined in these in a timely manner and this was impacting on the quality and safety of care for residents, particularly in relation to their home.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

There were admissions policies and procedures in place. Residents had contracts of care containing the information required by the regulations. However, one residents contract of care required review to include the actual fees they were paying in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had prepared a statement of purpose containing the information required under Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of incident reports in the centre and found that all information which should have been submitted to the Chief Inspector had been submitted.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents were protected by the policies, procedures and practices relating to

complaints in the centre.

Judgment: Compliant

Quality and safety

Overall, the inspectors found that residents were happy living in the centre, and that they were supported and encouraged to exercise their choice in how they went about their day. However, improvements were required in relation to the premises, storage and documentation relating to medicines and the review and other documentation in the centre such as residents' assessments and personal plans.

Overall, the premises was homely and suitable in its design to meet the needs of residents. Residents' bedrooms were decorated based on their interests and preferences with plenty of space in which to store their clothes and belongings. There was sufficient communal space in living rooms and the kitchen and residents had space to follow their own routine and spend time in their favourite places indoor and outdoors to relax, watch television or engage in recreation alone or with staff. In line with the findings of this inspection, the provider had recognised that there were areas for improvement in relation to the maintenance and upkeep of the premises, but had not completed the required works to make these improvements. The inspectors viewed documentary evidence to demonstrate that the person in charge and PPIM's had escalated maintenance issues to the provider. Some of the areas requiring attention included damage to a number of floor surfaces, a number of areas requiring painting, damage to furniture upholstery, damage to kitchen cabinets and worktop surfaces, water damage following leaks which had been fixed, a hole in one of the walls and damage to one of the internal doors in the centre. The inspectors acknowledge that due to some unexpected costs relating to works required in the centre, that these works had to be prioritised over the required maintenance works.

Residents were supported to access their finances in line with their assessed capacity and choice. While residents did not have cash or cards to hand, there was evidence that were equipped and supported to buy what they wanted in person and online at any time. Cash retained by the staff was secure and appropriately recorded to safeguard resident money. Residents had an inventory of their belongings which was kept up to date.

Residents had an assessment of need in place and a personal plans which were person-centred. However, from the sample of residents' plans reviewed, the inspectors found that there were some inconsistencies across documents and some duplication. Some documents were not fully reflective of residents' care and support needs described by staff during the inspection. The staff who spoke with the inspectors were knowledgeable in relation to residents' care and support needs but the documents in place were not fully guiding the staff team to

support residents with their current care and support needs. Residents had an accessible version of their personal plan developed as required. There was evidence that residents had access to a keyworker and social stories were developed as required with residents to support them in their day-to-day lives.

Residents had access to allied health professionals in line with their assessed needs. They had their healthcare needs assessed and care interventions were in place for the majority of these healthcare needs. However, the inspectors found that some healthcare assessments were not fully completed and that there were care interventions in place for residents for healthcare needs that were not outlined in their healthcare assessments. All appointments with allied health professionals were logged and followed up on. The inspectors found that these gaps in documentation were not resulting in immediate risks for residents as staff who spoke with the inspectors, were aware of residents' healthcare needs and their wishes and preferences in relation to attending appointments.

There was a residents' guide available and on display in the centre. It was available in a format accessible to residents. It contained the information required by the regulations and was reviewed and updated as required. It contained information relating to services and facilities, terms and conditions of residency, arrangements for residents involvement in the running of the centre and details relating to the complaints policies and procedures in the centre.

Residents were being supported to communicate in line with their wishes, preferences and assessed needs. There was information available for residents throughout the centre which was in a format which suited their communication preferences. This information included; pictures of what staff were on duty, meal options, the complaints process, information on rights and advocacy and the safeguarding statement. Residents had an all about me document which outlined how to get to know them and how they communicated. Through speaking with staff and observing a number of interactions between residents and staff, it was evident that they were familiar with this residents' communication needs and preferences.

Residents were protected by the systems in place relating to risk management. There was evidence that centre and residents' risk assessments were regularly reviewed and updated. Residents' risk assessment were updated in line with their changing needs and learning following incidents. There was a safety statement and emergency plans in place, evidence of regular health and safety inspections, and checks and servicing of equipment.

There were a number of restrictive practices in the centre and there was evidence that these were reviewed regularly to ensure they were the least restrictive for the shortest duration. Residents were supported by the relevant allied health professionals and positive behaviour support plans were developed and reviewed as required. They clearly guided staff to support the residents using proactive and reactive strategies.

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. All allegations or suspicions of abuse were reported and

followed up on in line with the organisation's and national policy. Staff had access to training and refreshers to support them to be aware of their roles and responsibilities in relation to safeguarding. Residents had intimate care plans in place and they clearly outlined their care and support needs and preferences.

Overall, the house was suitably equipped to detect and extinguish fire. Staff and residents were clear on what to do in the event of an evacuation and were supported by suitable signage and emergency lighting. Practice evacuation drills took place regularly in the centre, including night-time scenarios. Residents each had a personal evacuation plans which plainly outlined their support requirements to evacuate quickly. These plans were informed by experience in the centre during practice evacuations and included guidance on what do to in the event of identified delays. All equipment such as fire extinguishers, smoke detectors and the alarm system were tested and certified as operational in 2019. Exit routes and fire doors were clear of obstruction. Inspectors observed that the surface of one internal fire door was quite damaged which compromised its effectiveness at containing the spread of smoke or fire. The provider identified that this door was due for replacement and in the interim had a risk assessment in place to manage this identified risk.

There were policies and procedures in place relating to medication management. Staff described the procedures in place for ordering, receipt, storing and administration of medicines. Audits including stock control audits were being completed regularly. There was evidence that medication related errors or omissions were reviewed and that learning following these reviews was shared with the team. The inspectors observed staff preparing medicines to administer to residents. They were observed to do this in an organised and safe manner. However, improvements were required in relation to ensuring the safe storage of medicines in the centre. The medication storage fridge did not have a lock on it. Staff described procedures in place for stock control and returning medicines to the local pharmacy; however, there was no separate secure storage area separate from other medicinal products, to store out of date medicines or those for return to the pharmacy. In addition, the inspectors reviewed a sample of residents kardex and drug recording sheets and found that in some instances, they did not detail the frequency of administration of some medicinal products or what time these medicines should be administered at. Staff were recording that they administered medicines but not always recording the time of administration.

Regulation 10: Communication

Residents were being supported to communicate in line with their assessed needs and wishes and preferences. Staff were found to be knowledgeable in relation to residents needs and preferences. Information was available throughout the house to support residents to communicate their wishes and to make choices in relation to their day-to-day lives.

Judgment: Compliant

Regulation 12: Personal possessions

The residents were supported to access and manage their property and finances in line with their assessed needs.

Judgment: Compliant

Regulation 17: Premises

Overall the premises was suitable in its size and design to meet the support needs of residents. Some areas of the house required attention to ensure the house was kept in a good state of maintenance.

Judgment: Not compliant

Regulation 20: Information for residents

The residents guide was in place and available for residents in the centre. It contained the information required by the regulations and was available in a format accessible to residents. It was regularly reviewed and changes made as required.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents were protected by the the risk management policies, procedures and practices in the centre. General and individual risk assessments were developed and reviewed as necessary. There were systems in place to respond to emergencies.

Judgment: Compliant

Regulation 28: Fire precautions

Overall, the house was suitably equipped to detect and extinguish fire, and staff were familiar with procedures to follow in the event of emergency. An internal fire door was compromised in its ability to provide effective containment in the event of fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were policies and procedures in place relating to medication management. Regular audits were being completed and there was evidence of learning following medication errors. Improvements were required in relation to the storage of medicines and documentation relating to the administration of medicines.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had assessments of need and personal plans in place. Improvements were required in relation to a number of documents to ensure they were reflective of residents needs and clearly guiding staff in relation to how to support them.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were being supported to enjoy best possible health. They were being supported to access allied health professionals in line with their assessed needs. However, discrepancies were found in a number of healthcare assessments and care interventions reviewed. They required review to ensure they were reflective of residents care and support needs and clearly guiding staff to support them.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Restrictive practices in the centre were reviewed regularly to ensure that the least restrictive measures were used for the shortest duration. Residents had access to

allied health professionals in line with their assessed needs and plans and guidelines were developed as required to support residents.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding in the centre. Allegations and suspicions of abuse are reported and followed up on in line with the organisation's and national policy.

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
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Mulhussey OSV-0002967

Inspection ID: MON-0022940

Date of inspection: 28/01/2020

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: The Housing Association that owns the property were contacted on 29th of January 2020. An architect's drawing for the day services building has been requested and ordered. The PIC has had series of communication and follow-up regarding same. Once received the Statement of Purpose will be updated and forwarded to the HIQA Inspectors.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Rosters for the Designated Centre are planned and scheduled one month in advance. The monthly roster for the person in charge of the Designated Centre is now documented on the Designated Centre's actual roster and is displayed on the wall together with thee daily in the visual roster Residents in the Designated Centre receive continuity of care and support by having familiar relief and agency staff to cover all regular staff members' leave. The current vacancy has been recruited for and a start date is imminent. All staff working in the Designated Centre have the required qualifications and skill mix to best support the residents and their specific assessed needs. The Person in Charge has obtained all staff information and documents specified in	

Schedule 2.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: All residents 'My Personal Plans' were audited, reviewed, actioned and updated. All Care Interventions have been reviewed and updated and are clear in guiding staff practice and the care support needs of residents to ensure best practice and continuity of care. All records on site pertaining to the residents will be reviewed and updated as required and will be available in hard copy and electronically as required.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All outstanding maintenance issues for the Designated Centre have been escalated to the Programme Manager and Regional Director to be addressed with the Housing Authority that own the property. The Designated Centres Annual Review for 2019 has been completed upon receipt of family and residents input. The outcome and recommendations from this review will be inputted on the Quality Enhancement Plan for the designated centre. The six monthly Provider review audit was completed on 19th of February 2020 and actions have been inputted on to the Quality Enhancement Plan for the designated centre. .	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and	

contract for the provision of services:
All Contracts of Care for the residents have been reviewed and updated to include the correct charges and have been filed in residents Care Plans.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
All outstanding maintenance issues for the Designated Centre have been escalated to the Regional Director and Programme Manager. The Housing Association that own the property has also been notified of work that needs to be addressed and applications for works to be completed have been submitted.

All residents have their own bedrooms.

The Designated Centre has garden space to the front, side and rear of the house. Residents can access these areas as they wish. The residents are welcome to have their family, friends and visitors come to their home as they wish and space is afforded to them for privacy with their visitors.

The residents have their own ipad/tablet, with wifi boosters around the house so as to ensure there is consistent access to their devices to aid their communication and provide accessible information.

All required facilities are in place in the designated Centre to ensure all assessed needs of residents are being met.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A new fire door was ordered for one resident's bedroom. This fire door has been installed. Risk assessments addressing fire safety in the designated centre are in place, four fire drills per year were completed. Two night staff on duty each night. One risk assessment rating was reviewed by the team and a new score was considered and agreed. There is a robust fire management system in place in the Designated Centre. All required fire equipment is in place and is serviced and maintained as required. Fire drills are scheduled for the year. All staff team members are trained in fire safety and all residents in the designated Centre have Personal Emergency Evacuation Plans (PEEPS) in place. Emergency plan is in place and fire notices are displayed to guide staff in supporting all residents out of the building safely in the event of a fire.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A new lock has been fitted on the small fridge in the staff room.
A locked box has been sourced and is in place in the staff office for all medications that are out of date that need to be returned to the pharmacy.

All Kardex's have been reviewed and updated, by the consultant and specific dates and times have been listed for each medication prescribed.

All medication in the Designated Centre are stored securely.

Self-medication assessments are in place for all residents in the Designated Centre.

There is a robust Medication Management system in place in the Designated Centre to guide and instruct staff on the management of medication in the DC. This system addresses the storage, prescribing, receiving, disposing and administering of all medications.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All residents assessed needs have been reviewed and all documentation in the care plans have been updated. Comprehensive care interventions have been developed and for all residents, implemented to guide staff practices to ensure all assessed needs of residents are met.

All residents 'My Personal Plans' were audited, reviewed, actioned and updated. All Care Interventions have been reviewed and updated and are clear in guiding staff practice and the care support needs of residents to ensure best practice and continuity of care.

A comprehensive health assessment has been completed by residents GP and is in place in each personal plan.

All personal plans are kept on site will be reviewed and updated as required and will be available in hard copy and electronically as required. There is an audit schedule in place to ensure the plans are actively monitored, reviewed and evaluated.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
All residents assessed needs have been reviewed and all documentation in the personal plans have been updated. Comprehensive care interventions have been developed for all residents. The care interventions are implemented to guide staff practices and ensure all assessed needs of residents are met.

All residents attend a GP within the community health centre. All residents are supported to attend all scheduled appointments with appropriate health professionals as required. A comprehensive health assessment has been completed by residents GP and is in place in each personal plan.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	30/04/2020
Registration Regulation 5(3)(b)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by full and satisfactory information in regard to the matters set out in Schedule 3 in	Not Compliant	Orange	24/02/2020

	respect of the person in charge or to be in charge of the designated centre and any other person who participates or will participate in the management of the designated centre.			
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	17/02/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/09/2020
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	24/02/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the	Substantially Compliant	Yellow	24/02/2020

	designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	17/02/2020
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	24/02/2020
Regulation 29(4)(a)	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 any medicine that is kept in the designated centre	Not Compliant	Orange	17/02/2020

	is stored securely.			
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	24/02/2020
Regulation 29(4)(c)	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 out of date or returned medicines are stored in a secure manner that is segregated from other medicinal products, and are disposed of and not further used as medicinal products in accordance with any relevant	Substantially Compliant	Yellow	17/02/2020

	national legislation or guidance.			
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).	Substantially Compliant	Yellow	17/02/2020
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.	Substantially Compliant	Yellow	17/02/2020
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	17/02/2020