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:	Ladywell Lodge
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	05 September 2019
Centre ID:	OSV-0003025
Fieldwork ID:	MON-0023985

About the designated centre

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

Ladywell Lodge is a centre situated on a campus based setting in Co. Louth. It provides 24hr residential care to ten adult male and female adults some of whom have complex medical needs. The centre is divided into two separate units which are joined by a communal reception area. Each unit comprises of a large dining/sitting room, additional small communal rooms, adequate bathing facilities, laundry facilities and an office. Residents have their own bedrooms. There is a large kitchen shared by both units where residents can prepare small meals and bake. Meals are provided from a centralised kitchen on the campus. Both units have access to a shared garden area where furniture is provided for residents use. The centre is nurse led meaning that a nurse is on duty 24 hours a day. Health care assistants also play a pivotal role in providing care to residents. The person in charge is responsible for two other designated centres under this provider. They are supported in their role by a clinic nurse manager in order to ensure effective oversight of this centre. Residents are supported to access meaningful day activities by the staff in the centre and have access to a "hub" on the grounds of the campus where they attend some activities. A bus is available in the centre which is shared between the two units to support residents accessing community facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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
05 September 2019	09:30hrs to 18:15hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

The inspector met seven of the residents residing in the centre. Two residents were gone on a day trip to Dublin and so the inspector did not get the opportunity to meet them. One resident spent a short time showing the inspector some pictures of a new community house they were moving to in the near future.

Residents were observed to be happy and were smiling and engaging with staff in a jovial manner. They appeared very comfortable in the presence of staff who were observed to know the residents 'communication styles very well.

Residents' bedrooms were personalised to their individual tastes and their personalities and likes were evident in the decor chosen.

The inspector observed that residents were engaged in activities for example; some were enjoying the nice weather in the garden, some were baking and one resident was going to a football match later in the evening.

Residents also had access to an 'activation hub' beside the centre where activities are available such as sensory activities, arts and crafts and forms of music therapy.

Capacity and capability

Overall the inspector found that while residents appeared well cared for in the centre, significant improvements were required in a number of regulations to ensure that a safe, quality service was provided for. This included, governance and management arrangements, fire safety, the premises, residents' records, health care needs and documentation for end of life care. Some improvements were also required in social care goals, residents rights and the notification of incidents. Prior to this inspection the provider had identified the need to implement a range of improvements in the centre and some of the improvements were already being addressed. This is reflected where relevant in this report. It was also evident that the provider has put some systems in place to learn from the findings of other inspections.

Effective management structures were in place to ensure oversight of the centre at the time of the inspection. However, these structures were not in place for a two month period earlier in the year and this had an impact on a number of the findings identified in this inspection.

The person in charge was responsible for three designated centres. In order to support the person in charge with this arrangement a clinic nurse manager was also

employed to manage the day to day operations and ensure effective oversight of the centre. The inspector found that for a two month period prior to June 2019 there was no clinic nurse manager to support the person in charge, meaning that the arrangements in place to manage the centre during this time were lacking. A new person in charge and a new clinic nurse manager had been appointed since June 2019, both of whom were in the process of identifying and improving the services being provided to the residents at the time of this inspection.

The provider had made appropriate arrangements for the key management positions in the centre. The person in charge was suitably qualified and had considerable years of experience working in the disability sector in various roles. They demonstrated a good knowledge of the regulations and had a good understanding of the improvements required in this centre to assure a safe and quality service to the residents. They facilitated the inspection and were able to demonstrate through audits that some of the improvements identified at this inspection were already being addressed. For example; improvements in social care goals for residents, some fire records and premises issues.

The provider had also a number of quality improvement initiatives in the wider organisation which would contribute to addressing the findings of this inspection. For example; a committee had been formed to look at a better system for the management of records in designated centres and to review end of life plans for residents. They also planned to review the policy on providing intimate care to residents. This informed the inspector that the provider was implementing learning from other audits/inspections conducted in their services.

The provider had the required systems in place to evaluate the quality of services in the centre including six monthly unannounced quality and safety reviews and the annual review for the centre. While some improvements were required to the six monthly reviews the provider had already notified the quality and safety team of this to ensure that this was addressed going forward. The provider had also implemented significant changes to the risk management procedures in the organisation. This would ensure that adverse incidents were responded to and risk assessments were reviewed in a timely manner. However, as documented in the next section of this report there were a number of areas of practice which required ongoing improvement and oversight in order to ensure that they did not impact negatively on residents. These issues related to premises, healthcare (including the documentation and decision making process for end of life care), residents' rights and fire safety.

Other audits were also routinely conducted throughout the year which included the review of restrictive practices and residents’ personal possessions.

There was sufficient staff in place to meet the needs of the residents. A planned and actual staff rota was in place. A shift leader was appointed every day in the centre to support staff. An on call service was also provided by nursing personnel 24 hours a day. Some planned and unplanned leave of permanent staff was covered by agency/relief personnel. A review of the staff rota found that the same relief staff were employed to ensure consistency of care to the residents. The inspector also

found that on days where two nurses were not on duty in the centre that the staff nurse was supernumerary in order to assure that residents' health care needs were being met.

Staff met said that they felt supported in their role, they were observed being respectful of the residents and appeared to know the residents well. While they were knowledgeable about the residents' needs for the most part, improvements were required in some areas as discussed later in this report under health care and fire safety.

Staff were suitably qualified and had been provided with training in order to support the residents needs in the centre. Some of the training provided included, manual handling, basic life support, infection control and dysphagia training.

Staff reported that they had supervision conducted with the person in charge/CNM1, however the records were not reviewed by the inspector on the day of the inspection.

Staff meetings were conducted in the centre. These meetings were attended by the person in charge and the clinic nurse manager. From a sample of minutes viewed by the inspector they were found to be comprehensive and outlined actions required to improve services where required.

Significant improvements were required to the records maintained in residents' personal plans. For example, information was duplicated, old records were still on file, some records were not completed in full, some assessments conducted by allied health professionals were not available and some records pertaining to the follow up a residents care could not be found

A copy of the incidents that had occurred in the centre were available in the centre. The inspector found that one quarterly notification had not been submitted to the Health Information and Quality Authority as required.

Regulation 14: Persons in charge

The person in charge is a qualified nurse with considerable experience working in the disability sector. They demonstrated a very good knowledge of the regulations and their responsibilities under these.

The person in charge is responsible for three designated centres with the support of a clinic nurse manager.

Judgment: Compliant

Regulation 15: Staffing

There was sufficient staff in place to meet the needs of the residents. A planned and actual staff rota was in place. A shift leader was appointed every day in the centre to support staff. An on call service was also provided by nursing personnel 24 hours a day. Some planned and unplanned leave was covered by agency/relief personnel, however from a review of the staff rota, the same staff were employed to ensure consistency of care to the residents.

Judgment: Compliant

Regulation 16: Training and staff development

All staff had been provided with training in order to support the residents' needs in the centre.

Supervision records were not reviewed at this inspection.

Judgment: Compliant

Regulation 21: Records

The records stored on residents' personal plans required significant review as information pertaining to the care of the residents was either difficult to access, duplicated, incomplete or not available in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

While the provider was in the process of identifying deficits and implementing improvements, given the findings of this inspection the inspector was not satisfied that the management systems in place were assuring that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored. Improvements were required in order to ensure ongoing effective oversight of the service in key areas which impacted on residents such as fire safety , healthcare and

premises.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared a statement of purpose containing the information set out in Schedule 1 of the regulations. This document set out the aims and objectives of the centre and had been reviewed and revised where necessary.

Judgment: Compliant

Regulation 31: Notification of incidents

A copy of the incidents that had occurred in the centre was available in the centre. The inspector found that one quarterly notification had not been submitted to the Health Information and Quality Authority as required.

Judgment: Substantially compliant

Quality and safety

The inspector found that some of the care and support needs provided to residents required review in this centre to ensure that a safe quality service was being provided. Significant improvements were required in fire safety, health care needs and premises.

It is this providers intention to close this centre as part of a wider de-congregation plan for the campus.

The premises were for the most part clean but some areas including windows were very dusty on the day of the inspection. Each resident had their own bedroom which had been personalised to reflect their own tastes and interests. However, due to the changing needs of the residents in the centre (who now required specific manual handling equipment) some of the bedrooms were no longer big enough to accommodate this equipment. This meant that some residents could not be supported in their own bedrooms when hoists were being used. The storage of equipment was also a problem as equipment was stored in a number of communal

areas on the day of the inspection.

There was a leak in the roof of one of the residents' bedrooms which had required the resident to move bedrooms six weeks prior to the inspection. This had not been fixed at the time of the inspection.

The back garden was not secured by a boundary wall/hedging in order to ensure residents privacy when they were in the garden. This had been identified by the person in charge.

There were also no records to verify whether some of the equipment used in the centre had been serviced in line with the manufacturers guidelines. The person in charge was in the process of addressing this.

At the last inspection it had been identified that the central heating system was not working. Since then the provider had reviewed options to address this. Their review found that in order to fix this problem the costs, would have been significant, may not have worked and would have caused considerable upheaval to the residents in the centre. Instead the provider had installed portable electric heaters in each room. The inspector found that while this was outside the norm, that the provider had measures in place to monitor and audit temperatures to ensure that residents were warm. From a sample of records viewed the inspector found that optimal temperatures had been maintained in the centre.

A sample of personal plans viewed found that residents had an up to date assessment of need, however as already stated earlier in this report the records maintained required significant review. Support plans had been developed which outlined the care and support to be provided to residents. An annual review had also been conducted with residents and their representatives to review and discuss the residents care.

Residents had been supported to create ' a life vision' for themselves. This information was used to develop goals which reflected their interests and hobbies. However, improvements were required in some goals to ensure that they were meaningful to the residents.

Residents had been supported to avail of national health screening services. Residents also had access to a range of allied health professionals including a GP, occupational therapist, clinic nurse specialists in health promotion and psychiatrist. However, some residents had been assessed by an allied health professional and the recommendations from these were not available in the residents' personal plans.

Improvements were also required to ensure that residents medical treatment had been followed up and facilitated. For example; it had been recommended that a residents' oxygen levels should be adjusted. This had not been done at the time of the inspection.

Two residents had end of life plans in place, the records maintained in relation to these were not comprehensive and did not include how the resident had been involved in the decision making process. In addition, there was no clear rationale for

why one advanced care intervention, a DNAR (Do Not Attempt to Resuscitate) was in place for a resident and some staff met were not aware that it was in place for this resident.

Two residents are transitioning from this centre to community homes in the near future. One residents transition plan was reviewed. This support process had only begun for the resident but the resident had already visited the new house, had discussed it with their family members, and was also in the process of getting to know their new community. For example, the resident had become a member of the local Gaelic football association and was attending a match on the evening of the inspection. The inspector was also shown a copy of a detailed transition work book to be completed with the residents prior to their transition to their new home. This provided assurances that the transition would be well planned for the residents.

There were fire management systems in place which included fire doors, emergency lighting and a fire alarm. Maintenance checks had been completed on fire safety equipment such as fire extinguishers. Staff also conducted fire safety checks on fire equipment, fire exits and the fire panel. However, there were no records to demonstrate that fire doors were checked by a competent person.

Documentation viewed by the inspector informed that a fire drill had taken place to demonstrate if residents and staff could be safely evacuated during the day and at night time. Residents' had personal emergency evacuation plans (PEEP's) in place which had all been reviewed in May 2019. However, one PEEP did not include the appropriate support needs of the resident in order to evacuate them safely. Staff could not provide assurances of the procedures to follow in this event either. The person in charge took actions to address this on the day to ensure that all staff were aware of the supports for this resident.

In addition, the fire drill conducted at night time had been simulated and the records did not indicate how this drill had been conducted. For example, it stated in the records that the observer had allowed 1.25 minutes for each resident to be hoisted, however, staff stated that it could take up to 3 minutes for some residents. This also needed to be reviewed.

It was identified by staff and the person in charge that the fire alarm in the centre was connected to at least four other designated centres on the campus. This meant that when other centres were testing their fire alarms weekly, the alarm sounded in this centre and staff from the other centres had to be present in this centre to reset the alarm. This was impacting on residents privacy in their home. This had been identified by the person in charge who was trying to resolve this at the time of the inspection.

A copy of the incidents that occurred in the centre were reviewed. All incidents were reported to the person in charge. Trending of incidents to inform learning were discussed at staff meetings in the centre. Individual risk assessments for residents were in place, all risks were to be collated on a risk register for the centre. The risk register had not been completed at the time of the inspection but this had already been identified through the providers own audits.

The registered provider had systems in place to protect residents from all forms of abuse. All staff had received appropriate training in relation to safeguarding residents and the prevention detection and response to abuse. Of the staff met, they were aware of the different types of abuse and the procedures in place to protect residents in such an event.

Residents had intimate care plans in place which were detailed, but some improvements were required to ensure that all intimate care procedures were outlined in the plans to ensure that their dignity was upheld. However, the inspector was aware that the provider was addressing this in the wider organisation and therefore considered this as part of their judgement.

The registered provider and the person in charge ensured that residents were facilitated to receive visitors in accordance with the resident's wishes.

Regulation 11: Visits

The registered provider and the person in charge ensured that residents were facilitated to receive visitors in accordance with the resident's wishes.

Judgment: Compliant

Regulation 17: Premises

There were no records in the centre to demonstrate whether some clinical equipment had been serviced or maintained in line with the manufacturers' guidelines.

One residents bedroom ceiling was leaking which required a resident to move to another bedroom in the centre. This had been ongoing for six weeks at the time of the inspection.

Due to the changing needs of the residents some of the bedrooms were not big enough to allow residents to be hoisted in their own bedrooms.

Equipment was stored in a number of communal areas on the day of the inspection.

Some areas of the centre were dusty. Windows had not been cleaned.

As already identified by the person in charge, the outside garden required a boundary wall/ hedge to ensure privacy for the residents while in the garden.

Judgment: Not compliant

Regulation 25: Temporary absence, transition and discharge of residents

Two residents were transitioning to a community house. One residents transition plan was reviewed. This process had only begun, the resident had already visited the new house, had discussed it with their family members, and was also in the process of getting to know their new community. For example, the resident had become a member of the local Gaelic football association. They were attending a match on the evening of the inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk management procedures in the centre were assuring that adverse incidents were reported and acted on in a timely manner.

Judgment: Compliant

Regulation 28: Fire precautions

Fire doors were not maintained/serviced by a competent person.

One residents PEEP did not guide practice in order to ensure this residents safety in the event of an evacuation of the centre. The person in charge took appropriate steps to address this on the day of the inspection.

The fire drill conducted at night time had been simulated and the records did not indicate how this drill had been conducted. Therefore the provider had not demonstrated how they could effectively evacuate the centre at night time.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans which contained an up to date assessment of need. However, as already outlined some of the information required review.

Some of the goals developed required review to ensure that they were meaningful to the residents social care needs.

Judgment: Substantially compliant

Regulation 6: Health care

The processes for documentation, decision making and communication with regard to end of life care required review. It was not clearly documented why one advanced care intervention, a DNAR (Do Not Attempt to Resuscitate) was in place for a resident and some staff met were not aware that it was in place for this resident.

The end of life plans in place for two residents required significant review.

There was no follow up to some recommendations made by health care professionals.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had systems in place to protect residents from all forms of abuse. All staff had received appropriate training in relation to safeguarding residents and the prevention detection and response to abuse.

Of the staff met, they were aware of the different types of abuse and the

procedures in place to protect residents in such an event.

Residents had intimate care plans in place. Some improvements were required to ensure that all intimate care procedures were outlined in the plans, however the inspector was aware that the provider was addressing this in the wider organisation and therefore considered this as part of their judgement.

Judgment: Compliant

Regulation 9: Residents' rights

The fire management systems in place for other designated centres on the campus was impacting on the privacy of the residents in their home.

Judgment: Substantially 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ladywell Lodge OSV-0003025

Inspection ID: MON-0023985

Date of inspection: 05/09/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1- The Person In Charge & the hosue manager have commenced auditing each residents individual personal plan (IPP). Timeframes for actions to be completed are being identified with the keyworker. 2- A new revised IPP structure has been introduced into the Designated Centre. All documentation templates have been reviewed. Documents have now been merged together or discontinued to ensure effective information is available at all times. 3- The Person in Charge is developing a local record retention protocol specific to this designated centre	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Person in Charge and House Manager have carried out a review of the following areas within the Designsted centre: Risk Management, Staff training, Individual Personal Plans, Residents Finances, Complaints, Safeguarding, Incidents within the Designate centre, Medication Management, Social Goals Setting, Hygiene Audit & Fire Safety. All areas for improvement highlighted in these reviews are reflected in the Quality Enhancment Plan for the Designated centre. 2. The Quality and Safety team have conducted an unannounced inspection in the Designated centre on 30th September 2019 & all actions are reflected on the Quality Enhancement Plan. 3. Any maintenance works highlighted within the Designated centre have been esculated	

to the Operations Manager & maintenance supervisior and a schedule of works will be developed for the completion of works.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1- NF39A Quarterly notification was submitted to the Authority on 6th October 2019.
2- All notification for the Designated centre are being submitted via the Portal

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1- The Person in Charge has developed a data base to monitor the servicing of clinical equipment.
2- The maintenance supervisior in conjunction with the Person in Charge are ensuring that equipment is serviced in line with manufacturers guidelines.
3- Records of servicing are being maintained within the Designated Centre
4- The roof in a resident's bedroom has been repaired and the resident returned to his own bedroom on 16/09/2019
5- The Occupational Therapist carried out a review of the Designated centre on 17/09/2019 in relation to the individual pieces of equipment the residents require and their personal spaces within the Designated centre.
The Occupational Therapist report was reviewed by a sub group and a decision has been made to renovate a bedroom within Ladywell Lodge. When this renovation is completed there will be sufficient space within each bedroom to meet the needs of the residents.
6- The layout of each room has been reviewed by Person In Charge & the house manager, in relation to how furniture is being placed within the bedrooms to ensure maximum circulation spaces is available for manual handling purposes.
7- The Person In Charge and the House Manager have reviewed the entire Designated Centre spaces to ensure each area is being utilised appropriately. Additional storage spaces have been identified to store pieces of equipment and any unused equipment is being stored external to the house or discarded.
8- There are updated cleaning schedules are in place for the Designated Centre, which includes window cleaning. Window cleaners are being sought for external window cleaning & the high internal windows.
9- The Boundary hedge has been highlighted by the Person in Charge to the Grounds Supervisor and this will be created as part of the ongoing development plan for the Designated Centre.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire doors were not maintained/serviced by a competent person.
The fire drill conducted at night time had been simulated and the records did not indicate how this drill had been conducted. Therefore the provider had not demonstrated how they could effectively evacuate the centre at night time.
1- The fire doors have been certfifed by a Fire Consultatnt & reports are available from the maintenance department.
2- Staff carry out daily checks of these door to ensure they are operational as outlined in the Fire Register
3- All the residents PEEPs have been review & updated by Person in Charge and House Manager to reflect the each individual's support needs.
4- The updated PEEPs have been discussed with the Fire Officer on 15/10/2019 to review the effectiveness of these plans.
5- A local protocol has been developed and outlines how the simulation of a night time fire drill occurs.

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:
1. The Person In Charge & the house manager have commenced auditing each residents individual personal plan (IPP). Timeframes for actions to be completed are being identified with the keyworker.
2. A new revised IPP structure has been introduced into the Designated Centre. All documentation templates have been reviewed. Documents have now been merged together or discontinued to ensure effective information is available at all times.
3. Social goals setting is being identified through the IPP audit & actions are been identfied to ensure the goals setting are meaningful to the person & SMART.
4. Supported Self Directed Living training is being introduced to staff members.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Person In Charge & house manager have reviewed both residents care plans & the following improvements have been implemented:
1. Both residents identified have an advanced medical directive in place.
2. These medical directives were developed after full MDT/ circle of support meetings were held.
3. Both directives were based on the person's medical presentation & health conditions.
4. Both directives were led by medical directors & medical consultant. All this information will now be reflected in a new plan of care template.
5. This documentation will also reflect how the resident has being involved & how their natural advocates support them in this decision making process. This template was developed in conjunction with the documentation review committee in relation to end of life care.
6. These decisions will be reviewed on a 6 monthly basis.
7. All staff will inducted into each person's plan of care to ensure effective care delivery.
8. All MDT recommendations being identified through the IPP audit & actions developed as part of the audit process.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
1. Alternative solutions to the main fire alarm panel location are being reviewed currently to ensure an effective & safe solution can be found.
2. To minimise disruption to residents in the designated centre there is a local procedure in place for planned alarm testing.

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 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	30/11/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/11/2019
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained	Not Compliant	Orange	30/11/2019

	regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	30/12/2019
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/11/2019
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	30/12/2019
Regulation 23(1)(c)	The registered provider shall	Not Compliant	Orange	30/12/2019

	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.			
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	30/10/2019
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	30/10/2019
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring	Substantially Compliant	Yellow	06/09/2019

	in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).			
Regulation 05(4)(c)	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 is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Substantially Compliant	Yellow	30/12/2019
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Not Compliant	Orange	30/10/2019
Regulation 06(3)	The person in charge shall ensure that residents receive support at times of illness and at the end of their lives which meets their physical, emotional, social and spiritual needs	Not Compliant	Orange	30/10/2019

	and respects their dignity, autonomy, rights and wishes.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Substantially Compliant	Yellow	30/11/2019