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:	Renua
Name of provider:	Saint Patrick's Centre (Kilkenny)
Address of centre:	Kilkenny
Type of inspection:	Short Notice Announced
Date of inspection:	02 June 2020
Centre ID:	OSV-0003500
Fieldwork ID:	MON-0029513

About the designated centre

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

Renua is a residential home located in Co. Kilkenny. The service has the capacity to provide supports to three adults over the age of eighteen with an intellectual disability. The centre currently caters for three residents. The service operated on a full-time basis with no closures, ensuring residents are supported by staff on a 24 hour 7 day a week basis. Residents were facilitated and supported to participate in range of meaningful activities within the home and in the local and wider community. The residents have the option to avail of general day, open from 09.30 to 16.00 Monday to Friday, where they can concentrate on developing their community presence. The property presents as a bungalow on the outskirts of a large town. Each resident has a private bedroom, with a shared living area space. The centre also incorporated a spacious kitchen dining area and a large garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 2 June 2020	09:30hrs to 13:00hrs	Deirdre Duggan	Lead
Tuesday 2 June 2020	09:30hrs to 13:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

The inspectors had the opportunity to meet with residents throughout the inspection as they participated in their activities. Due to the current national restrictions residents were now supported to participate in a range of activities within the centre in the local community in areas of safe social distancing and within the 5km limit. Staff were observed encouraging residents to adhere to social distancing in a respectful manner.

Some residents chose not to interact with the inspector and this choice was respected. On the whole, staff interactions with residents were positive and staff knew the resident likes and interests. Staff spoke on behalf of the residents, including an awareness of their needs from a holistic perspective. Staff advocated the identified needs of the residents and spoke of improvements to the service they strove to achieve. This included repair to premises and individual goals, one of which being repair to a wheelchair bicycle to promote community participation. Residents appeared very comfortable in their home and in the company of staff.

Staff and management were aware of the importance of family to each individual. Family contact was currently being maintained through phone call and social media platforms. Where possible and in accordance with national guidance individuals would get to see and wave at loved ones from a safe distance for all.

Capacity and capability

The inspectors reviewed the capacity and capability within this designated centre and it was evidenced that measures were implemented by the provider to ensure a safe and effective service was afforded to residents. This designated centre had previously been inspected in July 2019 and inspectors found that a number of improvements had been put in place since that inspection and that these improvements lent to an enhanced provision of effective and safe services to residents.

Since the previous inspection a new person in charge had been appointed to the centre, commencing their role in November 2019. A fitness interview had been conducted over the telephone with this person in the week prior to this inspection and inspectors also had the opportunity to meet with them on the day of this inspection. The person in charge was found to be suitably experienced and qualified,

with sufficient oversight of the designated centre and good knowledge of their role and regulatory responsibilities within the centre. The person in charge demonstrated a thorough knowledge of the support needs of the residents living in the centre and spoke at length with inspectors about various arrangements that were in place within the centre to accommodate these. The person in charge was observed to interact positively with residents on the day of the inspection and it was clear that they maintained a strong presence within the centre. Inspectors viewed systems put in place by the person in charge to ensure continuity of care for residents living in this centre and found them to be robust.

The provider had in place clear lines of responsibility and accountability as outlined by the statement of purpose in place for this centre. In the previous year, a number of changes of management had occurred in this centre and at the time of this inspection there was no person participating in management identified. The provider had recently recruited an individual for this position and they were due to commence in the weeks following inspection. In the meantime, the provider had made interim arrangements to ensure that the person in charge was adequately supported in their role.

The provider had systems in place to ensure the centre was regularly monitored and reviewed from a provider level. An appropriate annual review had been carried out in respect of this designated centre. A person had been nominated by the provider to carry out an unannounced six monthly visit and this had taken place in January 2020. A report had been compiled following this visit, with numerous actions identified in this report. Many of those actions had previously been identified in the annual review carried out in May 2019. On the day of the inspection, inspectors found that many of these actions had been since completed. However, some actions were outstanding at the time of this inspection. For example, identified areas of maintenance had not been addressed within the allocated time frame.

This inspection took place in the midst of the COVID-19 pandemic. Inspectors had the opportunity to view the contingency plan put in place by the provider in relation to this, including emergency governance plans and information relating to a dedicated nursing response team. A house folder was also in place that outlined an up to date management structure. Evidence that staff meetings and cluster meetings were occurring regularly was available for inspectors to view. There was an audit checklist and schedule in place that covered areas such medication, health and safety, and finance, with evidence that these audits were taking place as planned. Overall, the documents viewed by inspectors provided evidence of forward planning, identification of issues and actions in relation to these.

The person in charge had ensured that staff were facilitated to access appropriate training, including refresher training. This incorporated training that the provider deemed to be of a mandatory nature to meet the assessed needs of the residents. Such training included infection control and safeguarding. There were effective measures in place to ensure that training needs were monitored and any mandatory training needs addressed in a timely manner. However, a review of training was required in the centre to ensure staff were afforded with the skills and

knowledge to support residents at all times. Training were discussed as part of quality conversations which occurred between the person in charge and staff team. These conversations were an opportunity to discuss roles and responsibilities of the staff team, and for the staff members to raise any concerns they may have.

The registered provider had ensured the development of an effective complaints procedure. Through an organisational policy, staff and residents were provided with guidance on procedures to adhere to should a complaint arise. Through review of the complaints log it was evident that residents are supported and facilitated to submit a complaint should they wish. Complaints were addressed in a timely manner with the satisfaction of the complainant achieved. Details of the complaints officer were visible throughout the centre.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had ensured a full application was submitted within the required time frame.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the centre. The person in charge demonstrated good oversight of the needs of the centre. The person in charge was knowledgeable and committed to their regulatory responsibilities.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff were facilitated to access appropriate training, including refresher training. However, a review of training was required in the centre to ensure staff were afforded with the skills and knowledge to support residents at all times.This incorporated training that the provider deemed to be of a mandatory nature to meet the assessed needs of the residents.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had established a suitable directory of residents in the designated centre. This was available in the centre and contained the prescribed information.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had ensured the centre was adequately insured.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the designated centre that identified lines of authority and accountability. Management systems were in place in the centre to ensure that the service provided to residents was safe and appropriate to their needs. Adequate systems were in place in the centre to monitor the service provided to residents.

The registered provider had nominated a person to carry out an unannounced visit to the centre at least once every six months. A written report of annual and six monthly reviews had been carried out. Some actions identified in the May 2019 annual review and again in the January 2020 six monthly review had not been completed. The registered provider had put in place effective arrangements to supervise and support staff in carrying out their duties.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose. This had recently been updated to reflect a change in management within the centre. This contained the prescribed information and was available to view in the centre on the day of the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had provided notice to the Chief Inspector in writing within three working days following an adverse incident occurring in the centre.

Judgment: Compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

The registered provider had ensured effect procedures and arrangements were in place for periods when the person in charge is absent.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had ensured the development of an effective complaints procedure. Through an organisational policy staff and residents were provided with guidance on procedures to adhere to should a complaint arise.

Judgment: Compliant

Quality and safety

Inspectors reviewed the quality and safety of the service provided within this designated centre. The previous inspection had identified non-compliance in numerous areas. The inspectors found significant improvements had been made in some areas. However, on the day of this inspection some of non-compliance were identified in relation individualised assessment and personal plan and positive behaviour support.

The design and layout of the centre met the aims and objectives of the service. The centre presented as clean and tastefully decorated taking into account individual preferences. The kitchen area had been redesigned since the previous inspection to allow for more space, and photographs through added a homeliness to the centre.

Whilst overall the registered provider had made provision for the matters set out in Schedule 6, some repair works were required including repairs to the main bathroom and hallway. Water damage was evident at the base of bath. The garden was an inviting area with flowers beds and seated area. Residents had a favourite spot to sit in within this area.

Individualised personal plans were in place for all residents of the centre. Inspectors viewed a sample of the documentation relating to these. These were found to be comprehensive and detailed and included items such as a resident biography, evidence of regular input from the multidisciplinary team and support plans, for example in relation to areas such as intimate care and communication. The person in charge had identified deficits in the personal plans and had some plans in place around this. While inspectors found that the documentation had improved significantly since the previous inspection, on the day of this inspection two residents had not had an annual visioning meeting carried out and evidence of individualised goals for residents was absent or unclear.

The individualised personal plans also incorporated the health care needs of residents. Clear guidance was present to ensure that health-care needs were addressed by staff in a consistent manner. The registered provider had also ensured effective measures were in place with respect to infection control with clear guidance for place for staff regarding adherence to the current national guidance with regard to COVID 19.A daily newsletter for staff and residents ensured all individuals were directed to the location of information. All staff had completed relevant infection control training including hand hygiene and breaking the chain of infection. Whilst adherence to COVID 19 guidelines was paramount an overall awareness of importance of infection control was in place including wound care.

Records relating to positive behaviour support were available in the centre. A review of the incident log for the centre found that there was one resident that was noted to display behaviours of concern, including self-injurious behaviour on occasion. Some recent guidance that was developed locally in relation to this resident was available to staff. The information contained in this demonstrated that staff had a good knowledge of the resident and made reference to the residents behaviour support plan. However, while the resident did have a behaviour support plan in place, this document had been developed in April 2016 when this resident was living in another location and had not been reviewed or updated since. Staff spoken with were not aware of some of the strategies suggested within the behaviour support plan and some of the information contained in it, such as environmental considerations, was no longer relevant or up to date.

Records available also showed that in October 2019 a behaviour support specialist reviewed a safeguarding concern in detail and were happy that appropriate strategies to support the resident were in place both during and following the incident. However, this also included a recommendation that staff working with this individual should receive specific training to support them to maintain a low arousal environment. The person in charge confirmed with inspectors on the day that staff had not received this training or training in positive behaviour support. The restrictive practice policy in a folder in the house was noted to have a review date in

November 2018. A restrictive practice register was in place in the centre and inspectors found that the restrictions listed matched those notified to the chief inspector as required.

All staff had up to date training in relation to safeguarding vulnerable adults from abuse and child protection. Where safeguarding situations arose the provider had ensured that adequate measures were taken to protect residents. The person in charge spoke to inspectors about the finance pathway in place in the designated centre and inspectors reviewed records that supported this. A sample of residents' finances were reviewed and adequate safeguarding processes for these were in place. Pertinent polices such as a National Safeguarding policy and an Intimate Care policy were in place and had been reviewed as required. Intimate care plans were found to be detailed and appropriate to the residents. Information relating to advocacy was also available in the centre.

The registered provider had ensured effective systems were in place for the ongoing identification, monitoring and review of risk. Through the use of a risk register effective control measures were in place to reduce the likelihood and impact of identified risk. There was evidence that the risk register was regularly reviewed to include the current and changing risk of the centre including infection control, fire precautions and safeguarding. Effective control measures were in place. As required a standard operating procedure had been developed to ensure awareness of and adherence to relevant identified risks. Processes and procedures relating to risk were clearly set out in an organisational risk management policy, which also contained the regulatory required information.

Fire containment measures were in place in the centre, including fire doors and appropriate firefighting equipment. Equipment was serviced regularly by competent personnel. This included designated fire exits and emergency lighting. Systems for safe evacuation of residents and staff were present with clear guidance for staff on procedure to adhere to including personal evacuation plans.

Regulation 13: General welfare and development

Residents were observed to be relaxed and comfortable in their home and staff spoken to demonstrated a good knowledge and awareness of the residents and their support needs and preferences. Residents were provided with opportunities for community involvement and recreation as appropriate.

Judgment: Compliant

Regulation 17: Premises

The design and lay out of the centre met the aims and objectives of the service. The centre presented as clean and tastefully decorated taking into account individual preferences. Whilst overall the registered provider had made provision for the matters set out in Schedule 6 some repair work was required including repairs to the main bathroom and hallway.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect to the designated centre and ensured a copy was available to all residents.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured the development of a risk management policy incorporating the regulatory required information. Effective measures were in place for the ongoing assessment, management, and review of risk within the centre.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had ensured effective systems had been adopted to ensure procedures were consistent with infection control standards. This included adherence to national guidelines with regard to COVID 19.

Judgment: Compliant

Regulation 28: Fire precautions

Fire containment measures were in place in the centre, including fire doors and

appropriate fire fighting equipment. Systems for safe evacuation of staff and residents were present. Fire equipment was serviced annually and residents had personal evacuation plans in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Personal plans were in place for each residents. Overall, these were found to be comprehensive and detailed with evidence of multi-disciplinary input. However, two residents had not had an annual visioning meeting carried out and therefore had not had adequate input from residents and their family. Evidence of individualised goals for residents was absent or unclear and some of the information contained in the plans required updating to reflect the current status of the residents.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had ensured that residents were supported to achieve the best possible physical and mental health. Clear guidance was provided to staff to ensure supports required were provided in a consistent and respectful manner.

Judgment: Compliant

Regulation 7: Positive behavioural support

A positive behaviour support plan designed with appropriate allied health professional input was in place to support one resident in the management of behaviours. However, this plan had not been reviewed since 2016. Staff did not have the appropriate training to support residents fully in the management of behaviours and were not aware of some of the recommended interventions to support this resident.

Judgment: Not compliant

Regulation 8: Protection

All staff had up to date safeguarding training in place. Where safeguarding situations arose the provider had ensured that adequate measures were taken to protect residents. A sample of residents' finances were reviewed and adequate safeguarding processes for these were in place. Pertinent polices such as a National Safeguarding policy and an Intimate Care policy were in place and had been reviewed as required.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was operated in a manner which was respectful to the rights of each individual resident. Voting information was available in the centre. A number of easy read guides were observed relating to, for example, the finance 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	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Renua OSV-0003500

Inspection ID: MON-0029513

Date of inspection: 02/06/2020

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**
Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
SPC is currently reviewing the house specific training needs for each designated centre. A process has commenced of reviewing training provision in terms of incident management for all SPC employees. It has now been advised that MAPA training may be the most appropriate and this has been communicated with SPC Health & Safety/Training Department.
Senior Management team will be discussing this advice imminently. Part of this discussion is the need of a robust induction program in SPC, and the development of trainers within the service that have a broad skill base (e.g. can deliver training in MAPA, PBS, low arousal supports, autism awareness etc.) based on the needs in specific houses.

The systemic model of Positive Behaviour Support is currently being implemented across SPC, starting with the first workshop on the 21st July 2020 for all SMT, PICs and identified staff members from 11 selected SPC houses. The PIC of Renua will be part of this first training cohort.

The PIC has also requested a review of one person's behaviour support plan and give guidance and support to the staff team to implement strategies around same.

The PIC is receiving monthly updates regarding training needs for all employees in Renua. Through Quality Conversations the training needs are discussed and followed up with each employee.

There is a Quality Conversations policy in place. The policy outlines a standardised organizational framework for the implementation, continuing development and maintenance of a system of Quality Conversations for employees. These conversations aim to support employees and ensure their work practices and development are supported and overseen in a positive way.
Since the new PIC commenced work in Renua, all Quality Conversations are completed

as per SPC Policy. Action plans are developed with each staff member to support them in their role and follow up on actions to be completed.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC is responsible for the management of 2 designated SPC centres. The PIC is spending adequate time in each house to ensure oversight and support and has also 19 hours protected time assigned for PIC duties.

A new PPIM commenced work with SPC on the 08/06/2020 and is now supporting the PIC in her governance role for Renua. The PPIM will be completing Quality Conversations with the PIC as per SPC Policy and both are attending monthly Cluster meetings to ensure support and knowledge transfer within the service.

Outstanding actions from previous provider audits regarding the completion of visioning and implementation of Roles Base Planning have been actioned by the PIC and staff team since the inspection took place. Visioning meeting reviews have commenced for all people supported in Renua and will be completed by the 25/06/2020. Implementation of Roles Based Planning documentation is being used to document the reviews and evidence progress going forward regarding each person's roles and goals.

In house audits are complete by PIC and assigned staff members. The PIC signs off on all delegated audits to ensure actions are completed and followed through. This is part of her Quality Conversations with staff members.
Team meetings are held on a monthly basis. The minutes of those meetings are kept within the relevant house folder and staff have to sign off on same to ensure they have read and understood the items discussed. Going forward the PIC will assign staff members to discuss relevant points of SPC policies at team meetings to ensure all staff will understand and adhere to procedures as outlined in policies.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Health & Safety Department have submitted a request to Landlord of Renua to assist with the repair works of the bathroom in the designated centre. St. Patrick's Centre is currently awaiting a respond from the Landlord to review and schedule the necessary repair works in Renua. Health & Safety department has scheduled for repair works to be completed (subject to funding) latest by 30/12/2020.

The PIC has requested SPC maintenance department to complete repair works in the hall of Renua. Maintenance department will ensure the repairs to the wall and repainting will be completed latest by 30/08/2020.

Health & Safety Department has also confirmed that Renua property is listed for replacement of Windows under the SEI grant for 2021.

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:
The PIC and staff team have commenced review of each person's visioning on the 07/06/2020. All reviews for the gentlemen will be completed by the 25/06/2020. The Roles based planning documentation is being used for the review of the vision for each person and will be evidencing progress of roles and goals going forward.

Further training on SRV and the implementation of the Roles based planning toolkit is re-commencing in July 2020 in SPC, which will support the PIC and staff team in Renua in building their capacity and understanding in supporting each person developing roles and achieving goals as they wish.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC has requested a review of the person's behaviour support plan to be completed by the SPC Behaviour Support Specialist to ensure. The MDT annual review for the person supported in Renua is scheduled for the 30/06/2020.
The Assistant Director of Service and Behaviour Support Specialist have also proposed that a review of each person's behaviour support plan to be conducted as part of the annual MDT review. It was also agreed that going forward a review of a person's Behaviours Support plan to be completed 12 weeks after a transition to new home.

As outlined under Regulation the systemic model of Positive Behaviour Support is currently being implemented across SPC, starting with the first workshop on the 21st July 2020 for all SMT, PICs and identified staff members from 11 selected SPC houses. The PIC of Renua will be part of this first training cohort.
This training has been developed by SPC Behaviour Support Specialist, informed by current literature, policy and legislation related to supports for people with ID.

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 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	30/07/2020
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.	Substantially Compliant	Yellow	30/12/2020
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/12/2020
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	25/06/2020

	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 05(6)(b)	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 be conducted in a manner that ensures 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.	Not Compliant	Orange	30/07/2020
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	Substantially Compliant	Yellow	30/07/2020

	effectiveness of the plan.			
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Not Compliant	Orange	30/07/2020
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2020
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/07/2020