Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Camphill Community Duffcarrig
Name of provider:	Camphill Communities of Ireland
Address of centre:	Wexford
Type of inspection:	Unannounced
Date of inspection:	08 August 2019
Centre ID:	OSV-0003610
Fieldwork ID:	MON-0024712

About the designated centre

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

Camphill Community Duffcarrig consists of seven residential units located in a rural community setting, that can offer a home for a maximum of 25 residents. The centre provides for residents of both genders over the age of 18 with intellectual disabilities, Autism and those with physical and sensory disabilities including epilepsy. Each resident has their own bedroom and other facilities throughout the seven units that make up this designated centre include kitchen/dining areas, living rooms, cloak rooms, utility rooms and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff members and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	23

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
08 August 2019	09:30hrs to 19:25hrs	Conor Dennehy	Lead
08 August 2019	09:30hrs to 19:25hrs	Tanya Brady	Support

What residents told us and what inspectors observed

Inspectors visited three of the units which made this designated centre and met a total of 11 residents during the course of this inspection. While inspectors only met some residents briefly and did not have meaningful opportunities to engage fully with them, they were able to speak to some residents and to observe residents in their environments and in their interactions with staff and volunteers.

One resident spoken with talked positively of the life they led while living in the designated centre and indicated that they liked the staff and volunteers who supported them. The resident also spoke about their role as a health and safety officer for the unit where they lived which they enjoyed. Some of the activities which this resident participated in and enjoyed where also highlighted to the inspector such as pottery, bird watching, singing and movie nights. The resident said that the location of movie nights had been moved to ensure that residents were provided with a bigger television screen.

Another resident indicated to one of the inspectors that they were happy living in this designated centre. It was observed that this resident interacted with staff members present in a warm and positive manner throughout the inspection. This resident was also seen to be involved in some tasks within the unit they lived in such as making tea and answering the telephone. A resident in a different unit was observed to be involved in the preparation of food and indicated to an inspector how they carried out this task while another resident was involved in farm work on the day of inspection.

Throughout this inspection residents were seen to engage with staff members and volunteers on duty in an overall positive manner that was in keeping with the community ethos of the provider. Meal times were observed in two units which were seen to be sociable events. One resident requested to have their meal in the sitting room of the unit where they lived rather than in the kitchen/dining area and this request was facilitated by staff. This resident indicated that the meal they received was nice. It was also observed that where residents required support with their meals, assistance was given in a discrete and respectful manner.

Capacity and capability

The provider was making efforts to support residents' needs in keeping with the overall ethos of the designated centre. It was seen though that improvement was required to ensure that provider unannounced visits took place every six months and also to ensure that the use of agency staff members promoted a continuity of care

and support.

This designated centre had gone through a period of escalation and enforcement activity with HIQA during 2017. Following an inspection in March 2018, where an overall good level of compliance was found, the centre was registered until July 2021 to provide a residential service for a maximum of 25 residents. The designated centre had continued to be monitored since the time of registration and the purpose of the current inspection was to monitor compliance with the relevant regulations. During the course of this inspection, the inspectors visited three of the seven units which comprised this centre.

In line with the provider's model of care, the workforce in place to support residents consisted of paid staff members and volunteers. It was noted that since the previous inspection, the number of volunteers involved with the centre had decreased. Files were maintained for both staff members and volunteers. A sample of these were reviewed by inspectors all of which contained evidence of Garda Síochána (police) vetting. It was noted though that the files of some agency staff (staff sourced from an external agency) did not contain all of the required information such as full employment histories. Arrangements were in place for staff and volunteers to be supervised although some inconsistencies were observed in the frequency of some formal supervision for both.

Overall appropriate staffing arrangements, which was supplemented by the volunteers involved with the centre, were in place to support residents at the time of this inspection. It was noted though that the use of agency staff required review to ensure that a continuity of care and support was provided to residents. For example, it was seen that the use of agency staff contributed to some medicines errors and to cleanliness levels decreasing in one unit of the centre. It was seen though that the provider was making active efforts to ensure that a consistency of staff was provided to support residents. Staff members spoken with during this inspection demonstrated a good knowledge of residents' needs.

To ensure that the designated centre was appropriate to residents' needs the provider had management systems in place to monitor the operations of the designated centre overall. For example, it was seen that audits had been carried out in areas such as medicines and health and safety. A clear organisational structure had been established for this designated centre where regular meetings were held to review the running of the centre. In addition, key performance indicators were also complied on a monthly basis that facilitated oversight of the centre at provider level. During the inspection, a member of senior management informed inspectors about further changes the provider was in the process of making to facilitate increased oversight and support for this centre.

However, despite this it was seen that the provider had not consistently carried out some of its requirements under the regulations to maintain oversight of the designated centre. For example, under the regulations the provider is required to carry out unannounced visits to the designated centre every six months to review the quality and safety of care and support that is provided to residents. While such a visit had been carried out in March 2019 and was reflected in a written report with a

corresponding action plan to address issues identified, this was the only such visit that had been carried out since February 2018 for this centre.

The provider had carried out an annual review, another regulatory requirement, in December 2018. While this reviewed the designated centre against relevant national standards, it was seen that it did not clearly reflect the outcome of consultation with residents and their representatives. It was noted though that the provider did have systems for obtaining residents' feedback. These included the complaints procedure which was in operation in this designated centre. As part of this a log of recorded complaints was maintained in the centre which included details of the complaints made, any actions taken in response to complaints raised and the outcome of such complaints.

Regulation 15: Staffing

Overall adequate staffing arrangements were in place to support residents but the use of agency required review to ensure a continuity of care and support. Staff files were available for staff members which included evidence of Garda vetting. It was noted though that files which related to agency staff did not contain all of the required information such as full employment histories and evidence of qualifications.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff members were being supervised but there was some inconsistencies as to when formal supervisions were being carried out for some staff. Training was provided to staff members in various areas such as fire safety, safeguarding, manual handling and first aid.

Judgment: Substantially compliant

Regulation 23: Governance and management

Provider unannounced visits were not taking place every six months as required with only one such visit carried out between February 2018 and the time of this inspection. The most recent annual review did not clearly reflect the outcome of consultation with residents and their representatives.

Judgment: Not compliant

Regulation 30: Volunteers

Files were maintained for volunteers which included evidence of Garda vetting and written roles and responsibilities. Arrangements were in place for volunteers to be supervised but for some volunteers there was inconsistencies in the frequency of formal supervisions.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

A log was maintained of recorded complaints in the designated centre which included details of these complaints and actions which the provider had taken to acknowledge such complaints and respond to them.

Judgment: Compliant

Quality and safety

Active efforts were being made to support residents and to ensure that they were provided with a good quality of life while the fire safety systems in place had improved since the previous inspection. It was noted though that the resident mix in one unit of the centre required review to ensure that the needs of all residents living there could be met. Some improvement was also required in relation to the medicines practices in the designated centre.

Residents had individual personal plans which are required by the regulations and are important in identifying the needs of residents and outlining the supports required to provide for these needs. Inspectors reviewed a sample of such plans and it was noted that they had been informed by relevant assessments and provided clear guidance for staff and volunteers in how to support residents. It was also noted that residents' individual personal plans were subject to annual review which was done with the participation of residents and family members where appropriate. There were systems in place to identify specific goals for residents to achieve. Such goals were subject to review and evidence was seen that some goals were being achieved but for other goals it was noted that the records in place did not demonstrate if these goals had been progressed.

In keeping with the overall ethos of the provider it was observed, during this inspection, that residents were supported in a community environment. Residents were facilitated and encouraged to engage in various activities such as farm work, pottery, singing and overnight trips away. Such activities helped to meet residents' personal and social needs. It was also seen that residents' health needs were provided for. For example, it was noted during this inspection that residents were supported to access a range of allied health professionals where necessary such as general practitioners, dentists, clinical nurse specialists and dietitians. Such findings provided assurances regarding the systems the provider had in place support residents' needs but while inspectors saw evidence that such needs were generally being met, the resident mix in one unit posed challenges.

Prior to this inspection HIQA had been notified by the provider of some interactions between residents in one unit of the designated centre, including one such interaction the week before this inspection. An inspector visited this unit during the inspection where it was seen that staff were making efforts to reduce the frequency and possibility of such interactions while the situation was being closely reviewed with input sought from relevant allied health professionals where necessary. However, the particular needs of residents living in this unit meant that such interactions where likely to reoccur. As such the resident mix in this unit required review to ensure that the needs of residents could be met and it was noted that the provider had recently assessed one resident living there as requiring a different environment more suited to their individual needs.

However, it was seen that, where necessary, residents had positive behaviour support plans in place to guide practice. Such plans were developed with the input of relevant allied health professionals and staff members spoken with demonstrated a good knowledge of these plans and how to promote positive behaviour. It was noted though that some plans had not been reviewed in over 12 months to ensure that staff were provided with up-to-date knowledge to encourage residents to engage in positive behaviour. Records reviewed indicated that staff had been provided with relevant training in de-escalation and intervention. It was also seen that all staff and volunteers had undergone safeguarding training and evidence was seen that matters of a safeguarding nature were reported and followed up appropriately. Residents' safety was also promoted via the improved fire safety systems which were in place.

Previous HIQA inspections had found that the fire safety systems throughout the designated centre were in need of improvement. During the March 2018 inspection it was seen that the provider was in the process of completing works to address such areas although the fire safety systems continued to require improvement. At the current inspection it was noted, in the three units visited by inspectors, that appropriate fire safety systems were in place including emergency lighting, fire alarms, fire extinguishers and fire doors which are important in containing the spread of fire and smoke in the event of a fire. It was observed though that the use of some fire doors in the units visited required review to ensure that they functioned as intended.

The provider had ensured processes were in place for internal staff checks on the

fire safety systems to be conducted to ensure that they were in proper working order. However, it was seen, in one unit of the centre, that there was inconsistency as to when such internal checks were being carried out. It was noted though that fire safety training was provided to staff and volunteers while fire drills were being carried out at regular intervals. Residents had personal emergency evacuation plans (PEEPs) in place outlining the supports they needed to evacuate the centre if required. To support residents evacuate, staff and volunteers were assigned specific roles for evacuations and those spoken with had a good awareness of these.

Staff members spoken with also demonstrated a good knowledge of when residents were to receive particular PRN medicines (medicines only taken as the need arises). It was noted though that documentation in place relating to some PRN medicines did not clearly state the maximum amount of these medicines that were to be given to residents. Inspectors also reviewed other areas relating to medicines and saw evidence of some good practice such as the storage facilities provided and assessments carried out to determine if residents could administer their own medicines. However, it was also observed that, while medicines training was provided to staff members, there had been occasions where residents had not received their medicines as prescribed. While there was no indication that any resident suffered any lasting adverse outcome due to these, inspectors were not assured that the practices followed and training provided were ensuring medicines were being given in line with best practice.

Regulation 17: Premises

The three units which were visited by inspectors were seen to be presented in a homely manner. While generally these units were well maintained and clean, in one unit it was seen that parts of the floor and stairs required some maintenance while in another unit some rooms were seen to be in need of cleaning.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A risk management process was in operation and as part of this a risk register was maintained for the designated centre overall while risk assessments relating to individual residents were provided for identified risks. It was seen though that the risk relating to the presence of a balcony was not included in the centre's overall risk register while some risk assessments did not clearly outline the control measures to mitigate against identified risks.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety systems in the three units visits included fire alarms, fire extinguishers and emergency lighting. Provision had been made for fire containment with fire doors in place although it was observed that the use of these required review to ensure that they functioned as intended. Internal checks were being carried out to ensure that the fire safety systems in place were in proper working order. However, in one unit, it was not demonstrated that these had been carried out consistently. Records reviewed indicated that fire safety training had been provided while fire drills were also being carried out.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The medicines practices and training provided in this area needed improvement to ensure that residents received their medicines as prescribed. Some of the documentation around PRN medicines required review to ensure that the maximum of medicine to be administered was clearly stated.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The mix of residents in one unit of the centre required review to ensure that the needs of all residents living there could be met within that environment. While residents had goals in place, it was not consistently demonstrated that there were being reviewed to ensure that they were achieved.

Judgment: Not compliant

Regulation 6: Health care

Residents had care plans in place relating to identified healthcare needs. Access to allied health professionals such as general practitioners, dentists, clinical nurse specialists and dietitians was facilitated when necessary.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff were provided with relevant training in de-escalation and intervention. Residents had behaviour support plans in place to guide staff practice in this area. Some of these plans had been recently reviewed and updated but it was noted that some had not been reviewed in the previous 12 months to ensure that staff had up-to-date knowledge in promoting positive behaviour.

Judgment: Substantially compliant

Regulation 8: Protection

Evidence was seen that matters of a safeguarding nature were reported and investigated while protective measures were put in place where required. Staff members and volunteers were provided with relevant safeguarding training. One volunteer spoken with demonstrated a good understanding of what to do in the event of a safeguarding concern arising.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Camphill Community Duffcarrig OSV-0003610

Inspection ID: MON-0024712

Date of inspection: 08/08/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A recruitment drive underway to employ a relief panel of staff and to replace staff that have left the team. Operational and Finance reviews are now part of operational procedures. These are led by CEO with PIC and regional manager. The initial operational and finance review was assessmnet based and has delivered a WTE for each house in Duffcarrig. A review against this was completed on 23/05/2019 and a recruitment campaign continues to deliver the agreed WTE for the community. The WTE figure has been approved by HSE and the community is actively recruiting to reduce agency through fulling vacancies and establishing a relief panel. An operational and Finance review will be conducted again in autumn 2019 – completion date 31/10/2019 Completion date recruitment to agree WTE 15 /12/2019 HIQA schedule 2 audit to be completed for all agency staff currently working in the community 30/09/19	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Supervision schedules to be developed and maintained within each unit. Local HR administrator will develop a Supervision and appraisal matrix for the community	

and update monthly. The PIC will receive a two monthly supervision report from HR against the matrix and any deficits will be addressed through an agenda item on the management meeting.
House Coordination will bring training and development needs identified through supervisions to the management to the bi monthly management meeting where supervision matrix is reviewed.
The PIC will include review timeliness and quality of supervisions as part of PIC audit schedule.
The regional manager will include supervision process as part of six monthly unannounced inspections process

Completion date 30/10/2019

Supervision policy to be reviewed as part of national policy review process 31/01/2020

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider is conscious of the issue of conducting two six month unannounced inspections. This role had rested with the regional managers nationally which was proving challenging given the number of locations to cover. The expansion of the national team since Autumn 2018 included the introduction of national Quality and Safety roles. This has brought focus and resource to this important requirement for the provider both in terms of our own quality and assurance planning and in meeting our regulatory requirements. The provider is developing a revised audit schedule and is developing the auditing skills and knowledge in house to resource and an auditing resource for our six monthly unannounced inspections.
Time frame for completing next unannounced 31/10/2019
Timeframe for providing regional resource and schedule to conduct on going Reg 23 inspections 31/12/2019

The provider has been using an Annual Quality Review and Plan template based on the disability standards. This has been informed by local information arising from internal audits, complaints, national provider initiatves, local engagement with external advocacy and HIQA inspections / PAR and feedback and learning from HSE Safeguarding team.
A broader approach will be undertaken to be deliberative in engaging all stakeholders in a review of quality of provision by the provider. There are existing fora in place to engage with residents and families and these will be shaped towards informing the quality of experience and in setting shared objectives and associated goals for the coming year. Staff will also be engaged in reviewing quality and engaging in contribution to annual review and plan.
The national quality lead is in the process of revising the registers. The data emerging

from incident, accidents, episodes of behaviour of concern and complaints will be analysed and trend data for the community provided and review with the National Clinical lead and PIC / Regional manager. First national generated reports will be available from end October 2019 and first quarterly statistics and trends end on of January 2020 for the last quarter of 2019. Similar process of reports will be generated by the Safeguarding Lead.

Annual quality review for this location will be completed by 15/12/2019

Regulation 30: Volunteers	Substantially Compliant

Outline how you are going to come into compliance with Regulation 30: Volunteers:
Supervision schedules to be developed and maintained in each residential unit.
The PIC will receive a two monthly supervision report from HR against the matrix and any deficits will be addressed through an agenda item on the management meeting.
House Coordination will bring training and development needs identified through supervisions to the management to the bi monthly management meeting where supervision matrix is reviewed.
The PIC will include review timeliness and quality of supervisions as part of PIC audit schedule.
The regional manager will include supervision process as part of six monthly unannounced inspections process

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Each house coordinator to complete a maintenance schedule of required works to ensure That houses are kept in a good state of repair.

One location needs dedicated deep clean action this will be completed by 10/09/19
A second location where painting and décor needs improving has been planned with maintenance team and will be completed by 30/09/19
Home hygiene will be monitored by HC and will be an item on mgt meetings
It will be included in audit of hygiene standards by DPIC to be completed by 30/09/19

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The provider is currently transitioning the risk assessment system to align with the HSE risk assessment system. The provider national H&S and Risk Management lead will review the finding under regulation 26 with the PIC and advise changes required.

A risk assessment in respect of the house with the balcony will be completed in consultation with the above provider lead and appropriate controls put in place.

Completion date 30/09/2019

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Daily fire checks are maintained in all units. On the day of inspection some of these had been archived. To provide further assurances Community health and safety officer to complete review of all fire safety folders. This will be carried out on a monthly basis going forward.
Review of daily checks being active and in place and in practice completed 30/08/2019
Magnetic door releases have been fitted to several fire doors in the Community

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Enhanced safe administration of medication
training to be provided by Clinical Lead (registered nurse). First training to take place in September 2019
Review of emergency medication protocols and Kardexs underway to ensure that maximum dose and intervals is clearly stated 20/09/19

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:
Audit to be conducted using HSE PCP template to review care plans and their associated goals for service users to ensure there is evidence of appropriate follow up on individual goals for service users.

Completion date 15/10/2019

A review of one resident whose quality of life and that of their peers is impacted by the nature of this person's needs and the overall number and layout of the house is required. The person's needs and the appropriateness of the house has been identified by the National Clinical Lead CCoI in June and was reviewed again in critical case review meeting on 30/08/2019.
The HSE, key family members and the previous service provider have been included in early discussions around futures planning process and insights into past successful approaches to planning transitions with the person. The person has an existing relationship with an independent external advocate.
The provider has a potential alternative single unit of accommodation for consideration as an option in conjunction with other housing and support options which the above contributors will engage with around the person.
The discovery and options exploration actions have commenced and will be completed by 30/11/2019
The full transition to a more individualised model of care, support and accommodation to be completed by 31/03/2020

In the interim the existing safeguarding measures will be maintained and reviewed by the PIC in consultation with the Regional Safeguarding lead.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC will audit all Behaviour Support Plans to assess last review dates and other actions required reflective of incident reports for each person. Completion 31/10/2019

The provider's regional Behavioural Support Specialist has visited the community and reviewed a number of key behaviour support plans as prioritized by the PIC. The external Behavioural Support Specialist will also remain available to the provider for a number of

people where support and review are currently being provided.
Plans identified in the PIC audit as needing review will be actioned by the PIC and team in consultation with the above behavioral specialist inputs.

Reviews of actions arising from audit 31/10/2019.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	15/12/2019
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/09/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/10/2012
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/01/2019

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/01/2019
Regulation 23(1)(e)	The registered provider shall ensure that that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	15/12/2019
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/10/2019
Regulation 26(2)	The registered	Substantially	Yellow	30/09/2019

	provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Compliant		
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/08/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/08/2019
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	30/09/2019
Regulation 30(b)	The person in	Substantially	Yellow	30/10/2019

	charge shall ensure that volunteers with the designated centre receive supervision and support.	Compliant		
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2020
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	31/10/2019
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.	Substantially Compliant	Yellow	31/10/2019