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:	St. John of God Kerry Services - Beaufort Campus Units Area 1
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	14 May 2019
Centre ID:	OSV-0003630
Fieldwork ID:	MON-0024687

About the designated centre

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

The designated centre provides residential full-time care to 28 male and female adults. Residents have a range of moderate, severe and profound intellectual disability with complex medical care needs including dual diagnosis and high physical support needs. Accommodation is in four separate premises. Between six and eight residents resided in each premises. All accommodation is at ground floor level and is part of a large campus. Most bedrooms are single occupancy bedrooms.
One premises had two bedrooms, one which accommodated three residents and one that accommodated two residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	28

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
14 May 2019	09:00hrs to 19:00hrs	Michael O'Sullivan	Lead
14 May 2019	09:00hrs to 19:00hrs	Lucia Power	Support

Views of people who use the service

The inspectors met with 12 residents on the day of inspection. Many residents had complex care needs and significant communication difficulties. Some the of residents were off site attending day services and day programmes or were involved in external activities during the course of the inspection. The inspectors observed interaction between residents and staff and it was evident that staff had a very good understanding of residents needs. The residents appeared to be happy with the support of staff and this was evident through gestures and sound. The inspectors noted the positive and warm engagement between staff and residents.

Capacity and capability

The inspectors found that since the last inspection there was no increased opportunity for residents to access the community or to take part in daily one to one activities, this was an identified action in the last inspection.The registered provider had a statement of purpose in place, however there were omissions in relation to visiting arrangements, fire precautions and associated emergency procedures. The staffing complement identified in the statement of purpose did not reflect the staffing numbers rostered in the designated centre.

The proposed staff roster for the day of inspection was as per the actual staff numbers and skill mix on duty. Previous rosters reviewed demonstrated staff gaps and staff movement across the designated centre. Nursing staff presence at night in one premises was subject to sharing on alternative weeks with another designated centre. The staffing levels allocated to night times were insufficient to meet the assessed needs of the residents. The information given to the inspectors was of one staff member allocated to each premises with an additional nursing assistance shared between all premises.

The registered provider had in place a directory of residents that was up to date and contained all prescribed information.

There was evidence that the registered provider was committed to a variety of training modules to improve staff performance and enhance the professional care given to residents. The records provided to the inspectors indicated that twenty one of forty three staff required refresher training in managing behaviours that challenge and all forty three staff required mandatory refresher training by a registered and certified fire and safety instructor.

The inspectors reviewed a sample of five staff members human resource files in the

presence of a service administrator. All information and documentation pertaining to the staffs' present and previous employments as prescribed by schedule 2 were in order. A review of two sample volunteer files contained current national vetting certification, references and a job description.

The registered provider had a complaints procedure in place, however, a complaint made by staff in relation to residents safety and staff numbers was deemed incorrectly made by management and was reviewed by a manager who was involved in the matters which were the subject of the complaint. There was evidence demonstrating that the person in charge had responded to the complaint, however, no further action was taken. Complaints were well maintained in a complaints log, however there was little evidence to demonstrate how outcomes were made prior to closing the complaint.

Notification of adverse incidents were submitted to HIQA within the prescribed time-frames. The inspectors noted the lower incidence rates which were also consistent with the providers recording and submission of national incident review forms.

The registered provider had in place an annual review and carried out unannounced visits in the designated centre, however the annual review did not include consultation with residents.

Regulation 15: Staffing

The registered provider did not ensure that the number, qualifications and skill mix of staff was appropriate to the number and assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge did not ensure that staff had access to appropriate training, including refresher training.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in the designated centre.

Judgment: Compliant

Regulation 21: Records

The registered provider had in place records and documents for staff as required by schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

While the registered provider had management systems in place in the designated centre, these systems did not ensure that service provision was safe, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place, however, it did not accurately reflect visiting arrangements, staffing complements and fire and safety precautions / procedures in place.

Judgment: Substantially compliant

Regulation 30: Volunteers

The registered provider ensured that volunteers had national vetting bureau disclosures and a job description in place.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had notified the Chief Inspector of all adverse incidents in the

designated centre within 3 working days.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place, however, outcomes and actions arising from complaints were not clearly documented.

Judgment: Substantially compliant

Quality and safety

Overall inspectors observed positive and gentle interactions between staff and residents that was respectful and kind. Staff demonstrated good knowledge of the residents they provided direct care to and there was evidence that the registered provider supported staff development and provided training for professional development. While some needs of residents were met to a good standard, the realisation of some residents' goals were not achieved and predominated by campus based activities that limited interaction with the wider community. Areas of non compliance highlighted in the previous inspection still remained outstanding and this was noted by the inspectors on the day of inspection.

The inspectors noted that there was little improvement in the quality and safety of services to residents since the last inspection. The registered providers commitment to addressing deficits in the quality of premises and the respect of residents' rights remained unresolved. Non compliance with fire and safety regulations were compounded by observed poor fire and safety practices, the absence of adequate precautions against the risk of fire, a failure to provide suitable mandatory training to staff and the absence of actions by the provider to address poor fire evacuation drill times.

The registered provider had a fire safety precautions statement in place that clearly instructed staff not to hold open or wedge open fire doors or remove any self closing devices. It was evident to inspectors that doors were held open, had no self closure device or had devices that were broken or deactivated. While the registered provider had provided fire awareness training to staff, all forty three staff were not in receipt of refresher mandatory fire and safety training by a certified instructor. Residents had a personal emergency evacuation plan in place, however, the fire evacuation time ranges for three premises where residents with complex needs and physical dependencies resided were not within acceptable limits. Fire evacuations recorded at times of minimum staffing levels were ineffective. All

fire detection systems and fire extinguishers were serviced and certified. Staff recorded regular daily and weekly checks in relation to fire and safety, however records in relation to fire doors were un-checked. There was no evidence that fire and safety concerns were escalated to management or actions arising in relation to these matters. The current risk register for the service was up to date but did not reflect the recorded fire evacuation times, staffing levels or poor fire and safety practices as an identifiable risk. Inspectors also noted that a radiator in the corridor of one premises was too hot to touch and a danger to residents. This radiator was immediately turned off by maintenance staff.

Some premises were well maintained, homely and well decorated with evidence of personal input by residents. A premises with six residents was in need of repairs and decoration. Floor coverings in a number of premises were damaged and in need of replacement. The kitchen and food preparation area was not suitable or sufficient to meet the needs of some residents or provide space to allow training or involvement in food activities. Improvements planned for one premises remained at tender stage to address personal bedroom spaces for residents where shared bedrooms were still in operation and items belonging to the service or to other residents were stored in residents' bedrooms. One resident with significant sensory loss and sensory needs was accommodated in a bedroom that was insufficient in size and separated from the main unit. While the provider was aware of this, discussion at team meetings awaited a decision. It was also observed that one room designated as a family / visitors room was utilised by staff as a cloakroom.

There was evidence that residents continued to share bedrooms impacting on individual dignity and choice. Some issues brought to the providers rights committee on behalf of residents had no response in a period of 18 months. Residents' files were on open display in a communal area within one premises. Inspectors were of the view that residents rights were not upheld.

Practices in medication administration and storage was observed to be good. Documentation was accurate, clear and up to date. All medications were securely stored and clearly labelled. The person in charge had introduced a system of medication management and storage that assisted staff with suitable training to support residents on social outings.

A sample of residents' individual care plans were reviewed by the inspectors. It was evident that not all residents' plans were up to date. Set goals had not been achieved and in some instances it was noted that staff shortages impacted on achieving goals. The individual care plans were not provided to residents in an easy to read format.

There was good evidence of health care plans and follow up in relation to residents. However, not all health related issues had a specific health care plan, for example one resident who had osteoporosis did not have a specific care plan in place. There was good evidence of positive behavioural support for residents requiring this support, records were clear and it was evident there was ongoing review and tracking of information.

There was some evidence of residents accessing the community, however this was very limited in relation to recreation and occupation.
Of some records reviewed by the inspectors, one resident had access to off site campus activities twice in a 4 month period. Another resident had fourteen community activities compared to 686 campus based in a four month period. Goals identified in resident plans for community based activities had not been met.

Regulation 11: Visits

The person in charge did not ensure that a suitable private area was available to receive visitors in some premises.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Most residents had access to their own property, however not all residents had adequate storage to maintain their own clothes and property which was stored in other residents bedrooms.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The registered provider did not ensure that all residents had access to facilities for occupation and recreation in line with residents interests, capacities and developmental needs; and supports to develop and maintain links with the wider community.

Judgment: Not compliant

Regulation 17: Premises

The registered provider did not ensure that the premises was designed and laid out to meet the aims and objectives of the number and needs of residents.

Judgment: Not compliant

Regulation 26: Risk management procedures

The registered provider did not ensure that there was an effective system in place for the assessment, management and ongoing review of risk.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider did not ensure that effective fire and safety management systems were in place.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

The person in charge had appropriate systems in place for the safe administration, storage, receipt, prescribing and disposal of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge did not ensure that some residents' personal plans assessed the effectiveness of the plan or took into account changes in circumstance or new developments.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had in place appropriate healthcare for each resident, however, this healthcare plan was not always reflected in the resident's personal

plan.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The person in charge ensured that staff had the necessary knowledge and skills to respond to behaviours that challenge to support residents manage their behaviour.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider did not ensure that some residents privacy and dignity was respected.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Views of people who use the service	
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 30: Volunteers	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. John of God Kerry Services - Beaufort Campus Units Area 1 OSV-0003630

Inspection ID: MON-0024687

Date of inspection: 14/05/2019

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The recruitment drive will continue to be implemented to fill existing gaps in the compliment and the Programme Manager will review the recruitment strategy quarterly to pre-empt and respond to leavers as they arise. 15(1) A business case has been submitted to the HSE to increase by one additional staff across the campus at night to meet the care and support needs of residents in both designated centres on site. This request has been approved and recruitment process commenced. Completion date 31st July 2019 An additional vehicle will be purchased and adapted for the Designated Centre to further increase the implementation of resident's goals to access the community. Completion Date 31st July 2019 15(2) The staffing complement described in the Statement of Purpose will be reviewed by the PIC and the Programme Manager. This review will be carried out for each location within the DC and will also include a breakdown of the skill mix. Completion Date: 21st June 2019	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

16(1)(a) 7 (1)
One Location in the DC has been identified as a priority for behaviour training in this location where there is potential for behaviours that challenge. One staff member is currently completing a nine month longitude course.
The Practice Certificate in Multi Element Behaviour Support (MEBS)
Completion Date:28th February 2020

16(1)(a) 7 (2)
All staff in the above location are up to date with CPI/ MAPA and behaviour training which includes de-escalation and intervention techniques.
Completed 14th June 2019

16(1)(a) 7 (1)
The PIC will allocate staff identified in training log for behaviour training in line with the planned schedule to ensure all staff in the DC are availing of same through workshop or MEBs on line.
Completion 30th March 2020

16(1)(a)
The PIC will allocate staff to Fire Safety awareness with a competent person to bring all staff up to date.
Completion Date: 30th November 2019

16(1)(a)
The PIC and Unit Manager will review the implementation of Safe Administration of Medication and identify any barriers to implementation of Service Policy to support resident's access to community in one location.

A strategy will be put in place to support staff in addressing any identified barriers and provide additional training/mentoring where required.
Completion Date: 30th March 2020

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
23(1)(a) The staffing complement described in the Statement of Purpose will be reviewed by the PIC and the Programme Manager. This review will be carried out for each location within the DC and will also include a breakdown of the skill mix and night cover allocated in each location.
Completion Date: 21st June 2019

23(1)(c) The Registered Provider will complete a risk assessment with the PIC and local

unit managers to assess the risk of non-compliance with SJOG Policy/Procedures due to the non-escalation to senior management of safety critical data such as Fire Drill evacuation protracted times and other related safety information including the reporting of maintenance issues with a view to identifying additional control measures required on the governance of same.
Completion Date: 30th June 2019

23(1)(e) The PIC will include consultation with residents through the support of keyworkers in the collation of the 2019 Annual Review.
Completion Date: 30th March 2020

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
03(1)
The Statement of Purpose document has been reviewed by the PIC and now includes additional information pertaining to visitors, fire safety precautions and staffing complements.
Completion Date 20th June 2019

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
34(2)(a) Informal complaints will be resolved at local level and these will be recorded on the complaints log and noted as informal.
Completion Date 31st July 2019

34(2)(a)
Informal complaints that are unresolved at local level will be escalated to the nominated complaints officer (external to the Designated Centre) for further investigation. Any new formal complaints will be referred to a nominated complaints officer outside of the Designated Centre.
Completion Date 31st July 2019

34(2)(f)
The PIC in consultation with the relevant complaints officer will review the existing log and ensure all complaints are up to date and the associated documentation records the

outcomes and actions arising from the complaints. Completion 31st July 2019

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits: 11(3) (b) The visitors room highlighted in the body of the report has been cleared of the staff lockers allowing for a more appropriate area for residents to receive visitors. Completed 11th June 2019

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: 12(3)(a) One resident's wardrobe has been relocated which allows easier access to the residents personal clothing. Completed 28th May 2019 All residents' bedrooms have now been inspected by the PIC to ensure that all items are personalised to the individual. The PIC is now confident that each resident's bedrooms is personalised to the individual and that no service belongings are retained in the resident's personal space. Completed 12th June 2019

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: 13(2)(a) An additional vehicle will be purchased and adapted for the Designated Centre to further increase the implementation of residents goals to access the community.

Completion Date 31st July 2019

13(2)(b)
The PIC has commenced a new recording system in one location to assess and monitor the level of community outings in line with the residents goals.
Completed 10th June 2019

13(2)(c)

The PIC and unit manager will introduce a system in one location where a planned schedule of activities is completed for the week ahead to increase the number of activities that each resident can avail of in accordance with their wishes.
Completion Date 30th September 2019

The PIC and Unit Manager for the location will monitor and review the implementation of community activity on a monthly basis as part of the Designated Center's scheduled meetings.
Completion Date: 31st December 2019

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Schedule 6 (5)
The Registered Provider will provide additional suitable storage space in staff offices for files that are currently being retained in communal areas as part of the schedule of maintenance
Completion Date: 31st July 2019

17(1)(a) 17(7)
The Registered Provider in partnership with the Relative and Friends association will complete the construction of two additional bedrooms in one residential area. This project has completed the procurement process and sufficient fundraising monies are in place to progress the project.
Completion Date 31st March 2020

17(1)(a)&(1)(b)&(1)(c) 17 7
The registered provider has consulted with suitably qualified architect who has confirmed renovations to the room identified as "insufficient size" are not feasible in this location
Completed 28th May 2019
The PIC will prioritise this resident in the room identified as "insufficient size" for transfer to a single room once a suitable vacancy becomes available
Completion Date 30th November 2020

The registered provider has completed an audit of all doors within the DC and immediate

damage to intumescent strips in rooms have been repaired.
Completed 6th June 2019
The door identified as broken in the body of the report has been repaired.
Completed 21st May 2019

The area identified as requiring decoration will be added to the planned schedule of painting and completed in consultation with residents and keyworkers in the location.
Completion date 30th March 2020

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
26(2)
The registered provider has completed a risk assessment to identify additional control measures required to ensure that effective fire safety management systems are in place including responding to emergencies.
Completed 6th June 2019

The Registered Provider will review the above risk assessment to monitor the risk and implementation of the additional control measures identified to ensure that effective fire safety management systems are in place.
Completion date 30th June 2019

The PIC will escalate all safety critical data through the Campus Quality meeting as a standing agenda item at the Campus Quality meeting quarterly.

September 30th 2019

26 (2) 28(3)(d)
A business case has been submitted to the HSE to increase by one additional staff across the campus at night to meet the care and support needs of residents in both Designated Centres on site. This role will also have positive impact on evacuation times at night. This request has been approved and recruitment process commenced.

Completion date 30th June 2019

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: 28(2)(a) 28(2)(b)(i) The Registered Provider has completed a risk assessment to identify additional control measures required to ensure that effective fire safety management systems are in place including responding to emergencies. Completed 6th June 2019 Audit has been completed on Fire Doors. All doors identified as requiring replacement of intumescent strips have been carried out. Completed 6th June 2019 Wider intumescent strips and smoke seals have been fitted to all cross corridor doors where required. Completed 17th June 2019 The repair or replacement of existing door closers in two units in the DC based on the fire safety consultants advice and sign off. Appropriate replacement units have been sourced and will be fitted. Completion date 31st July 2019 28(2)(b)(i) The registered Provider has engaged an external fire consultant to test the current operation of the existing automatic door closers and all are confirmed as working correctly. Completed 5th June 2019 28(2)(b)(ii) The Registered Provider will review the fire safety management risk assessment to monitor the risk and implementation of the additional control measures identified to ensure that effective fire safety management systems are in place. Completion date 30th June 2019 The above risk assessment will be placed on the risk register and reviewed in line with the risk management policy i.e. monthly for red rated risk and 3 monthly for orange rated risks. Completed 30th June 2019 28(3)(d) The Registered Provider will review existing night time fire drill information and complete additional fire evacuation drills at night to ensure there are appropriate supports in place to respond in the event of an emergency. Completed 6th June 2019 One additional staff will be assigned across the campus at night to respond to any emergency and to meet the care and support needs of residents in both Designated Centres on site. 30th June 2019 28(4)(a)	

Fire safety training by an external competent facilitator will form part of the annual training calendar to maintain staff training levels within the required 24 months.
The Registered Provider has commenced an accelerated fire safety training programme (currently weekly) by a competent external fire safety company to provide the required mandatory training to staff in the Designated Centre.
Completion Date 30th November 2019

The Registered Provider will engage fire safety consultant to review initial remedial works once completed to ensure the centre is in compliance with the relevant legislation as it applies to this Designated Centre.
Completion Date 31st October 2019

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:
5(5) The PIC and unit manager staff are completing documentation using a more visual format which is deemed more accessible, in so far as practical, based on each residents needs and complexities. This process will include advice from the SLT department to explore additional options to support accessibility of plans to residents.
Completion Date: 30th March 2020

05(6)(b)
The PIC in consultation with the Unit Manager invites the individual's representative/ Family member, where appropriate, to view the individual's personal plan at the annual planning meeting as well as any other meetings that may emerge. This will be documented in each residents plan at the time of the planning meeting.
Completion date: 30th June 2020

5(6)(b)&(c)&(d)
Staff meeting to be facilitated by the PIC highlighting review of personal plans to be conducted annually, or more frequently if a change in need emerges. Highlighted the need for reviews to assess the effectiveness of the plan and residents goals
Completion Date: 30th June 2019

Support sessions will be made available to keyworkers by the Project Manager to provide mentoring to key workers where required. Attendance at these sessions will be monitored by the PIC in consultation with Unit Managers.
Completion Date: December 2019

5(6)
The PIC, in consultation with the Unit Manager, has reviewed the existing schedule of residents planning meetings and quarterly reviews to ensure each residents plan is

subject to review annually or more frequently if required.
Completed 14th June 2019

This process and the status of plans will remain a standing agenda item on the PIC and Unit Manager meeting Agenda.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
6(1) The PIC will arrange the review of Healthcare plans Section 5 to ensure all plans are up to date and reflect the individual's current healthcare needs.
Completion Date: 30th September 2019

The PIC will complete an audit of Healthcare Assessment and Health Action Plans in the DC following the aforementioned review to ensure compliance.
Completion Date: 30th November 2019

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
09(3)
The PIC in consultation with unit manager will support two residents to transition to individual bedrooms on the completion of the planned extension in one location. This will further reduce the current numbers within shared bedrooms in this location.
Completion Date: 31st December 2019

9 (2)(c) & 2(d)
The Registered Provider has requested a full review of the Rights documentation in relation to residents in the Designated Centre. This will include recommendations in relation to the governance and management of the referral process and response issues identified.
Completion Date: 30th September 2019

This review will include any rights referrals identified that have not been responded to by the Human Rights Committee the PIC will follow up with same to obtain a response if the restriction is still in place.
Completion Date: 31st December 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 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required.	Substantially Compliant	Yellow	11/06/2019
Regulation 12(3)(a)	The person in charge shall ensure that each resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	28/05/2019
Regulation 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and	Substantially Compliant	Yellow	12/06/2019

	possessions.			
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/07/2019
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	10/06/2019
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	30/09/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/07/2019

Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	31/07/2019
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.	Not Compliant	Orange	30/03/2020
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/11/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/03/2020
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Not Compliant	Orange	30/03/2020

	designated centre are clean and suitably decorated.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/03/2020
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	22/06/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/06/2019
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.	Not Compliant	Orange	30/03/2020
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Orange	30/06/2019

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	30/10/2019
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.	Not Compliant	Orange	05/06/2019
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/06/2019
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them	Not Compliant	Orange	30/06/2019

	to safe locations.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	20/06/2019
Regulation 34(2)(a)	The registered provider shall ensure that a person who is not involved in the matters the subject of complaint is nominated to deal with complaints by or on behalf of residents.	Substantially Compliant	Yellow	31/07/2019
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/07/2019
Regulation 05(5)	The person in charge shall make the personal plan available, in an accessible format, to the resident and, where appropriate, his or her representative.	Not Compliant	Yellow	30/03/2020
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is	Substantially Compliant	Yellow	30/06/2020

	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.			
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	30/06/2019
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	Substantially Compliant	Yellow	14/06/2019

	take into account changes in circumstances and new developments.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/09/2019
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.	Not Compliant	Orange	31/12/2019