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:	Heather Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Roscommon
Type of inspection:	Unannounced
Date of inspection:	08 and 09 October 2019
Centre ID:	OSV-0004461
Fieldwork ID:	MON-0027919

About the designated centre

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

Heather services, is a residential service located on the outskirts of a busy town in Co Roscommon and is run by Brothers of Charity Services, Ireland. Heather Services can provide accommodation and support for up to seven (7) adults with intellectual disabilities in two separate bungalows in residential areas. There are six bedrooms in the larger building and three bedrooms in the second building. All residents have their own bedrooms with some having ensuites. There are also adequate communal rooms for people to have visitors and privacy. Residents currently living in the larger building have high support needs. They are supported with a staffing skills mix of senior staff nurses, staff nurses, social care workers, community facilitator and community connectors. Waking night duty and sleepover staff applies in this house. People avail of day services from their home. Transport is provided to access work, education/training and leisure facilities in the community. One resident with high support needs lives in the second building full time with a staffing skills mix of social care leader, social care worker and community connector. Waking night duty and sleepover duty applies in this house. The person supported avails of day service from their home and transport is provided to access work, education/training and leisure facilities in the community. Residents are supported to be active participating members of their local communities. They use the local amenities including – restaurants, public houses, hotels, shops, parks, cinemas, arts centres, libraries, church, bowling alley, and swimming pools.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 October 2019	14:30hrs to 17:30hrs	Eoin O'Byrne	Lead
09 October 2019	10:00hrs to 17:00hrs	Eoin O'Byrne	Lead
08 October 2019	14:30hrs to 17:30hrs	Sarah Barry	Support
09 October 2019	10:00hrs to 17:00hrs	Sarah Barry	Support

What residents told us and what inspectors observed

The centre comprised of two buildings, the larger house was supporting five residents and the second house had one resident residing there.

The larger house was split into two sections with three residents living in one area and two in the other. Parts of the building appeared dated and required decorating. The layout of the centre also led to poor natural lighting in some areas.

The inspectors spent time in both parts of the larger house. One section of the larger house was found to be a challenging and busy environment with some residents moving in and out of rooms on a constant basis and others engaging in loud vocalisations around mealtimes. The inspectors observed staff members prepare a dinner for residents and found this period to be challenging. Some residents appeared to struggle with the transition between the meal being prepared and it being ready to consume. The staff members who were supporting residents appeared to have strong understandings of the residents' behaviours and their communication skills. Staff members were observed to seek to support the residents during the meal preparation period.

Inspectors spent time in the second section of the larger house and found it to be spacious with a well-lit kitchen and living room. This environment was a more relaxed one and inspectors observed staff members being able to sit and interact with the residents on a one to one basis.

The inspectors visited the second house where one resident was being supported. The resident had recently transitioned into the centre. The centre was modern and laid out to meet the needs of the resident. Staff members informed the inspectors of recent positive developments associated with the move including increased social engagement and activity.

The inspectors met all 6 of the residents during the course of the inspection. However, some of the residents chose not to interact with the inspectors and this was respected.

The inspectors interacted with two resident who were willing to do so. Both residents did not use verbal communication but interacted in a friendly manner with the inspectors and those supporting them. One resident sat with the inspector and person in charge in the centres office for a period as they appeared interested in what was happening. The person in charge appeared to have a positive relationship with the resident and explained why the inspector was visiting the centre.
The inspector and person in charge then sat with the resident in a sitting room. The resident appeared happy and excited during this time but did not appear interested in interacting with the inspector. The inspector respected this and removed themselves from the environment.

Inspectors met with another resident who had just returned from a social activity with the support of staff. The resident was interacting non verbally with the staff members through prompting and gaining their attention. The resident appeared at ease and appeared happy when the staff members were informing the inspector of the social outing that they had returned from. The resident was then supported to have their lunch by the staff members.

Capacity and capability

There were aspects of the service that were not well run and required attention. The governance and management systems that were in place were not effective at ensuring that residents' needs were consistently met and that their rights were upheld.

The centre was notifying the chief inspector at the end of each quarter about the use of restrictive practices in the centre. As part of this process some concerning information was notified which indicated that inappropriate restrictive practices may have been in use due to reduced staffing levels. In particular there was a concern that a resident may have been inappropriately physically restrained.

The provider was required to respond and provide assurances regarding appropriate staffing arrangements and the use of restraint. The provider was given two opportunities to respond to the concerns raised. The initial response from the provider did not adequately address the issues of concern. The identified concerns were then raised with a member of the provider's senior management team. This member was also given the opportunity to respond to the concerns. Both responses received by the office of the chief inspector failed to provide the necessary assurances that the provider had understood, identified and addressed the matters raised. The matter was escalated as a regulatory risk and this unannounced risk based inspection was initiated.

This risk based inspection found that despite raising concerns with the provider on two occasions the provider had failed to identify and address issues in the centre regarding the use of restraint. As a result an immediate action was issued to the provider during the course of the inspection requiring them to take steps to ensure no resident would experience unauthorised restraint. The provider took prompt action and provided written assurances in this regard before close of the inspection. However, overall concerns still remained regarding the quality and safety of care being provided at the centre. As a result the Deputy Chief Inspector issued a warning letter to the provider and the provider was invited to attend a meeting in HIQA's Smithfield offices to address the findings in more detail and the need for a targeted response.

There was a need to review and address the staffing resource in the centre. Staffing arrangements were not always appropriate to meet the needs of residents and this had an impact on arrangements for the use of restraint. As a result there had been

unauthorised use of physical restraint on two separate occasions and it was not demonstrated that the provider was upholding residents' freedoms and right to liberty. While the provider had ensured that there were sufficient staffing levels being provided to meet the complex needs of the residents on most days, staff absences due to sickness during weekend periods had led to staff members utilising unnecessary restrictive practices due to a reduction in staffing numbers. This restrictive practice was impacting upon the resident's rights and dignity. The provider had acknowledged that this practice had occurred on one occasion and had reported same to HIQA. However, during the course of the inspection, it was found that the restrictive practice had been utilised again three days prior to the inspection due to a reduction in staffing levels. The provider was not aware that the practice had been utilised until highlighted by the inspectors. This did not provide assurance that the provider had adequate oversight of this area and inspectors were concerned that there was a risk of further use of unauthorised restraint. As a result the immediate action was issued.

The management structure in place was not effective. Management systems had been developed but they were not effective in regards to ensuring that the service being provided to the residents was consistent, monitored and appropriate to the residents' needs. The management structure was made up of the person in charge and senior staff nurses who delegated to the staff team. Inspectors found that there was insufficient management presence in the centre. There was not effective oversight of the centres staffing levels, staff members' practices in relation to supporting and respecting the rights of residents and supporting residents to achieve social care goals. As a result there was direct negative impacts on residents in these areas.

An unannounced visit had been carried out by the provider as per the regulations. A written report had been prepared following this visit that reviewed the safety and quality of care and support provided in the centre. The inspector observed that a plan had been put in place regarding actions raised. Some actions had been completed within the identified time frame; however there were a number of actions including the completion of works to the building and the updating of the centres roster that had not been completed within the set time frame.

It was found during the course of the inspection that the provider and person in charge had failed to inform the chief inspector off all restrictive practices being implemented in the centre. As a result the inspectors were not assured that the provider had systems in place to identify and record the use of restrictive practices appropriately as per the regulations.

Inspectors did observe that the provider and person in charge had systems in place that ensured that adverse incidents were investigated and reviewed appropriately and that learning from incidents was prioritised. However, there was a lack of evidence that the provider and person in charge had promoted learning following the inappropriate use of the restrictive practice on the first occasion.

The provider had ensured that the qualifications and skill mix of staff were appropriate to the number and assessed needs of the residents. However, the

provider had on more than one occasion failed to ensure that the number of staff members supporting the residents was appropriate to meet the needs of the residents. Inspectors found that the centres planned and actual rosters were disorganised and required attention in regards to their layout to ensure clarity. A review of the rosters and a discussion with staff members highlighted that there were staffing vacancies present in the centre. Residents were, however, being provided with continuity of care and support despite the staffing issues. Consistent locum staff members were being utilised by the provider.

Overall, it was found that there was an absence of effective and responsive management systems to ensure that residents were receiving a safe and consistent service. The oversight and auditing of practices being carried out in the centre required review. The provider had identified prior to the inspection that an increased management presence was necessary in the centre and had put plans in place to respond to this by November of this year.

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the necessary qualifications and experience to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Inspectors observed that there had been occasions where the provider had failed to ensure that there were appropriate staffing levels in place to meet the needs of the residents. The provider had also failed to ensure that there was effective oversight of staff practices being carried out in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems that were in place in the centre required review in relation to ensuring that the service being provided to the residents was consistent, monitored and appropriate to the residents' needs. It was observed that the monitoring of residents and the centres information required attention in areas such as the use of restrictive practices and the development of social care goals for residents.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider and person in charge had failed to inform the chief inspector off all restrictive practices being implemented in the centre.

Judgment: Substantially compliant

Quality and safety

The quality and safety of care provided to the residents required review and improvement. The provider had failed to ensure that all practices in the centre respected the rights and dignity of the residents. Whilst residents' health care and medical needs were being comprehensively provided for, the systems in place to address their social care needs were not effective in all cases. There were a number of areas that required attention in regards to the standard of care and support being provided to residents. Areas included residents' rights, the use of restrictive practices, access to residents information in relation to an agreement regarding the vehicle in the centre and supporting residents to plan and achieve personal goals.

Inspectors reviewed a sample of residents' personal plans and found that residents were not being supported to achieve their individual social care goals. Residents were being supported to go on activities such as drives and walks but there were no active social goals documented for the sample of resident's files that were reviewed. There had not been an update to the actions to achieve social care goals since late 2018. While goals had been recently set, there was no evidence of actions being taken to realise these goals. The last set of goals that had been identified had requested additional staff for several hours a day to allow a resident to realise one of their goals but this had not been put in place. There was evidence that a personal outcome measures meeting was due to take place in September, however, this was cancelled due to a resident being unwell. Inspectors were therefore not assured that the centre was adequately resourced and organised to meet residents social care needs.

There were appropriate arrangements in place to meet the medical and healthcare needs of residents however. Residents had access to medical and healthcare services and appointments were being facilitated and supported as required. Residents accessed a range of medical and healthcare services including speech and language therapists, physiotherapists and chiropody services. Residents had hospital passports in place and these had been reviewed recently which was a positive initiative to support continuity of care in the event of a hospital transfer. There was

evidence of staff putting measures in place to facilitate residents' needs in attending medical appointments. Residents had an annual medical review that reflected any changing needs. The inspector spoke with a staff member who provided a comprehensive overview of one resident's healthcare needs. There were also support plans in place for identified health needs.

Residents were receiving appropriate positive behaviour support. Where required, residents had positive behavioural support plans in place. A review of a sample of these plans found them to be detailed and regularly reviewed by the centre's staff team and members of the provider's multi-disciplinary team. The inspectors observed recording sheets where residents' behaviours were being documented and then presented to the provider's behaviour management specialist for review. This practice was leading to positive measures being developed to support residents and those working with them.

As referenced in section one of the report there were significant concerns regarding the use of restrictive practices, in particular the use of a restraint and how these practices were being managed. The inspection found that the provider had failed to ensure that all restrictive practices being utilised in the centre were applied in accordance with national policy and evidence based practice. The usage of restrictive practices due to staff shortages was not an acceptable practice and provided evidence that those supporting the resident had not considered all alternative measures before utilising a restrictive practice. Inspectors observed that there were systems in place to record restrictive practices being implemented in the centre. There was evidence of some practices to ensure that the least restrictive practice was being utilised. Some restrictive practices had been discontinued and trial periods had been completed to review the possible reduction of other practices.

The provider had failed to ensure that information regarding financial safe guarding measures for residents were available for inspectors to review. Residents living in one of the houses that made up the centre had been supported to purchase a vehicle for their use. The inspectors sought to review the contracts that had been drawn up regarding the purchasing of the vehicle which should have been in place to ensure that residents' financial interests were safeguarded. However, these contracts were not available for review on the day of the inspection. The provider could not therefore demonstrate that appropriate controls and consultation had been put in place to safeguard residents.

Inspectors observed that the provider had responded to put protective steps in place when safeguarding incidents had previously been raised. Inspectors found that investigations into the care being provided to residents had taken place and that safe guarding measures had been implemented. The person in charge had ensured that the staff team had received the appropriate training in relation to safeguarding residents and inspectors reviewed notes from additional training that had recently been provided to the staff team

While there was evidence that members of the staff team and the person in charge were liaising with the provider's rights committee regarding restrictive practices, there was clear evidence that the rights of all residents had not been considered in

regards to the usage of restraints.

There were systems in place to manage and mitigate risks and keep residents and staff members safe in the centre. The centre had arrangements in place to identify record, investigate and learn from adverse incidents. Risk assessments were detailed and reviewed regularly by senior staff nurses and the person in charge. The centre was utilising an online recording system to record adverse events and a member of staff described how the staff updated the information and forwarded the information to members of the provider's multi-disciplinary team.

Compatibility issues between residents had been raised in the previous inspection report. As a result, two residents had completed transitions from the main house. Inspectors visited both houses that made up the centre. The larger house required attention in relation to its decoration and layout. The provider had acknowledged this and an action was set following an audit that took place in March 2019. The works had, however yet to be carried out.

The second house had recently been opened and was designed and laid out to meet the aims and objectives of the service and the needs of the resident.

There were systems in place to ensure the prevention of fire, and the safe management of any emergency. The appropriate servicing and maintenance of equipment including the centres fire panel, had taken place, and regular fire safety checks were undertaken and documented. Inspectors observed that effective and regular fire drills were taking place in both houses that made up the centre and that there were personal emergency evacuation plans on file for residents.

Inspectors observed that there were positive elements to the care being provided to residents by those supporting them. These however were being overshadowed by practices that did not promote the rights of residents. There was also a lack of management presence and oversight that was impacting upon the standard of care being provided to residents.

Regulation 11: Visits

Inspectors observed that residents were receiving guests and that there was suitable private area for residents and their guests to meet.

Judgment: Compliant

Regulation 17: Premises

The inspectors visited both houses that made up the designated centre. The provider had acknowledged prior to the inspection that one of the houses required updating and decoration.

The second house had recently been opened and was adequately laid out to meet the needs of the resident residing there.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were risk management procedures in place that maintained the safety of residents and those supporting the residents.

Individualised risk assessments were under regular review and there was clear evidence that learning was generated following the review of adverse events.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured that effective fire safety management systems were in place.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Inspectors found that residents social care needs were not being appropriately addressed. There were no documents evidencing active social goals for the sample of resident's files reviewed.

While goals had been set recently, there was no evidence that residents or their representatives had been involved in their development. There was no evidence of actions being taken to realise these goals.

Judgment: Not compliant

Regulation 6: Health care

The provider had ensured that appropriate health care arrangements were in place for residents. Residents had access to various medical professionals as needed. An annual review of resident's medical needs was carried out, reflecting any changing needs of the residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

A sample of residents behaviour management plans showed that they were reviewed and updated when necessary. There were a number of restrictive practices being utilised in the centre that were effectively monitored and implemented. However a restrictive practice had been implemented on two occasions that was not appropriate and was not being monitored effectively.

Judgment: Not compliant

Regulation 8: Protection

Residents living in the centre had purchased a vehicle for their usage. A contract had been drawn up outlining the ownership and maintenance of the vehicle in order to safeguard residents' financial interests. However, this contract was not available to be reviewed by the inspectors and therefore the provider could not demonstrate that appropriate controls were in place.

Judgment: Not compliant

Regulation 9: Residents' rights

There was evidence that the rights of a resident were not considered when a restrictive practice was implemented due to staff shortages that impacted on the residents freedom to exercise choice and control over their daily life

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
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	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	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Heather Services OSV-0004461

Inspection ID: MON-0027919

Date of inspection: 08/10/2019 and 09/10/2019

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 rosters have been reviewed in both houses within the Designated Centre and there is scope on the roster for a staff to be available as a floating staff in either house. A protocol has been put in place will guide staff on to manage the roster in the event of a staff needing to take unplanned leave at short notice.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: There is a management structure now in place which will ensure that the service being provided to people supported is consistent, monitored and appropriate to the needs of the people supported. There is a Residential Services Manager/PPIM and a Team Leader who is on the roster and also has supernumerary hours to provide effective governance and management in the Designated Centre. This team leader will now be the PIC and is actively monitoring service provision on a daily basis.	
Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: There is a query on the practice in question being restrictive or supportive. The practice has now been referred to the Human Rights Review Committee for an independent review. The Practice will also be notified on the next NF39 returns.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The premises in question is currently being painted and redecorated with emphasis on both artificial and natural light.	

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: Further training is provided for the staff team in Person Centered Planning and Record Keeping. All plans will be reviewed. People supported and their representatives will be consulted with and evidence of actions will be recorded. A workshop has taken place on the 08/11/19. A further workshop is planned for 10/12/19 and a series of follow up workshops will be scheduled for 2020 to ensure compliance in this area.	

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: There is a clear protocol in place for the use of the restrictive practice in question. There is also a restriction log in place. This log is being monitored on a daily basis by the PIC/PPIM to ensure that no inappropriate use occurs. The protocol has been brought to the attention of all staff again and they have been asked to sign the protocol indicating that they understand fully the protocol in place and agree to only use the restriction as per the protocol. All restrictive practices are reviewed at all team support and supervision	

meetings with the ambition to remove restrictions where possible.

Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: While the contract was not available to be reviewed by inspectors on the day of the inspection there is a contract in place. This contract was reviewed previously as part of another HIQA inspection and was deemed to be compliant by the Inspectors. The contract was agreed in consultation with all relevant stakeholders, including family representatives and was also reviewed by a legal professional. This contract is now on file in the house.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: The rosters have been reviewed in both houses within the Designated Centre and there is scope on the roster for a staff to be available as a floating staff in either house. A protocol has been put in place will guide staff on to manage the roster in the event of a staff needing to take unplanned leave at short notice. There is a clear protocol in place for the use of the restrictive practice in question. There is also a restriction log in place. This log is being monitored on a daily basis by the PIC/PPIM to ensure that no inappropriate use occurs. The protocol has been brought to the attention of all staff again and they have been asked to sign the protocol indicating that they understand fully the protocol in place and agree to only use the restriction as per the protocol.	

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(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	Red	30/11/2019
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	15/11/2019
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	Not Compliant	Orange	09/12/2019

	to residents' needs, consistent and effectively monitored.			
Regulation 31(3)(a)	Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	07/01/2020
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	31/01/2020
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	18/10/2019
Regulation 08(1)	The registered provider shall ensure that each resident is assisted	Substantially Compliant	Yellow	10/10/2019

	and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	10/10/2019