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:	No.4 Fuchsia Drive
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	30 - 31 July 2019
Centre ID:	OSV-0004478
Fieldwork ID:	MON-0023382

About the designated centre

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

In this designated centre the provider aims to support people to live ordinary lives in their community in close connection with family and friends. A residential service is provided to a maximum of 15 adult residents. The designated centre is comprised of three houses in separate locations in relatively close proximity to each other. All three houses are in populated areas in the environs of the local busy town where a range of support services operated by the provider are also available to the residents. Each house can accommodate a maximum of five residents; residents share communal and dining space. The model of care is social and each house is staffed when residents are present in the house. The staff team is comprised of care assistants and social care workers led by the person in charge who is a registered nurse in intellectual disability nursing.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
30 July 2019	09:45hrs to 19:00hrs	Mary Moore	Lead
31 July 2019	09:15hrs to 14:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

There were fourteen residents living in the centre; one bed was vacant. The inspector spent time in each house and met with nine residents, one resident was at home with family and four residents had left for their respective day service before the inspector arrived on the second day of inspection.

Residents presented with a diverse range of needs and capabilities and residents communicated in different ways but all engaged and communicated their interest in the inspection and their views effectively. Residents welcomed the inspector to their homes and were curious as to the role and purpose of the visit. Some residents were more reticent than others but overtime demonstrated their increasing comfort with the inspector in their home.

Residents presented as well, content and happy with their lives; residents confirmed this. A common theme of discussions was day to day life and their individual roles and achievements in family and in society. Ongoing contact with family and friends was evidently important as was the activities and holidays that they enjoyed. Residents said that they loved going to the day service and then relaxing if they wished in the evening watching their favourite television programmes. The inspector saw that residents were comfortable and familiar with the staff on duty, knew who the "boss" was and told the inspector that it was good to have someone in charge. In response to their queries the inspector explained that the inspector's job was to establish that they had a good home where they were safe and received good support, residents said that they were happy and that all was good in the house. The inspector discreetly observed the implementation in practice of agreed supports on how staff and residents went about day to day routines together such as shopping and dining.

One group of residents collectively told the inspector that they were looking forward to moving to a bungalow so that they would have everything they needed without having to use the stairs. Residents said that this move would also give back to them the communal space that was lost in the reconfiguration. Residents hoped they would be in their new home when the inspector visited again.

Capacity and capability

The inspector found that there were unresolved issues that impacted on the quality and safety of the service provided to residents. The governance structure also

needed to be strengthened so that it operated at the optimum effectiveness and efficiency. However on balance governance of the centre was effective in that the provider itself had identified these issues, was aware of and acknowledged their negative impact and was, at the time of this inspection seeking to address them. These issues were not however resolved and related to the unsuitability of one premises, resident needs that were incompatible and residual issues to be finalised in relation to staffing levels.

The management structure specified by the provider to ensure the effective, consistent management and oversight of the service was a social care leader in each house reporting to the person in charge who in turn reported to the sector manager. There had been instability and change at all levels of this structure with further recent and pending changes such as a change in person in charge and pending changes in social care leader roles. Given the regulatory remit of the person in charge (four designated centres) it is important for these structures to be established and maintained to support effective governance. Some findings of this inspection had the potential for risk, were related to ongoing changes and were not reflective of consistent governance. For example the inspector noted the failure to issue reports from service and clinical reviews in a timely manner and consequently a delay in addressing deficits at the responsible level and in implementing clinical recommendations. There were gaps in communication where the appropriate information did not appear to be shared or known at the appropriate level. For example while there was evident feedback sought and obtained from representatives this did not appear to be shared with persons completing quality and safety reviews as it was not incorporated as a line of inquiry into these reviews. A further example was the lack of clarity as to the status of recommendations that had been made and that were designed to improve the quality and safety of the service such as the provision of an external ramp and chair lift in one house.

In general however the inspector found that the provider was proactive and responsive, for example in managing and deploying staffing resources. The importance of consistency, familiarity and routine for residents was recognised and factored into the staff rota. There was a requirement for relief staff but the same staff were employed on a regular basis; this was evident on the day of inspection. Staffing levels were increased in response to specific resident needs and risks and included 1:1 staffing arrangements. A staff presence was maintained in a house if a resident was staying at home be this planned or unplanned. The inspector was advised that a significant body of work had been undertaken in relation to staffing, staff deployment and the staff rota so as to regularise, optimise and reconcile staffing resources and resident needs. This work was not finalised however and there were some residual concerns as to the adequacy of staffing levels to meet residents increasing needs (safety, support and emotional needs) in one of the three houses. The limited residual times when there was only one staff on duty to support the five residents living in this house were described as challenging. An internal review described staffing in the house as adequate however, findings from this inspection indicate that further review was needed.

The social care leader role provided for supervision on a day to day basis, the person in charge was available as needed, had systems of oversight for matters

such as risks and accidents and incidents, and called generally unannounced to each house. Staff meetings were convened; staff recognised issues that impacted on the quality and safety of the service and did raise their concerns; this feedback from staff was reflected in the reports seen of reviews completed by the provider. The provider had a policy on formal staff supervision at regular intervals during the year for all grades a staff; however, this policy was not, with the exception of the annual appraisals being implemented.

Nursing advice and care and oversight of healthcare plans was available as needed from the person in charge and the community based nurse.

Staff spoken with had the knowledge, skills and attitude needed for them to perform their role and to provide residents with the care and support that they needed. Staff attendance at training and any requirement to attend training were monitored. The inspector reviewed staff training records and saw that staff had up to date mandatory, required and desired training.

The inspector reviewed the complaints log and saw that residents and/or their representatives did raise matters if they were unhappy with an aspect of the service. The inspector found that they were listened to, failings were acknowledged and action was taken in response to make things better. Complainant satisfaction with these actions was ascertained.

Regulation 14: Persons in charge

The person of charge met the requirements of Regulation 14 in that the person in charge worked full-time and was suitably qualified and experienced. Though recently appointed to the role the person in charge was familiar with the providers structures, policies and procedures from previous roles held. The person in charge was facilitated to become familiar and knowledgeable with the operation of the centre, residents and staff through a process of induction supported by the outgoing person in charge. The person in charge was clear on her responsibility to identify to the provider any obstacle that may arise to the effective management of all the designated centres concerned.

Judgment: Compliant

Regulation 15: Staffing

There were some residual concerns as to the adequacy of staffing levels at all times to meet residents increasing needs (safety, support and emotional needs) in one of the three houses. The limited residual times when there was only one staff on duty

to support the five residents living in this house were described as challenging. An internal review described staffing in the house as adequate, however, further review of staffing arrangements was needed.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with mandatory, required and desired training. Though the provider had yet to fully implement its formal supervision process, staff spoken with had the knowledge, skills and attitude needed for them to perform their role and to provide residents with the care and support that they needed.

Judgment: Compliant

Regulation 21: Records

There was scope for improvement in the creation and maintenance of records. For example there was duplication and records that were no longer relevant to the care and support provided noted in personal plans. It was difficult to extract the current information and to track the progress of actions, for example after MDT review.

Though evidence based there was a generic format for healthcare plans which did not always provider clear, individualised guidance.

The assessment and decision-making pathway for establishing resident choice and ability to manage their medicines was not recorded.

The way in which the provider identified, assessed, concluded, agreed and reviewed the restrictive dimension of interventions required for the safety of a resident was not recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

There had been instability and change at all levels of the management structure with further recent and pending changes. Some findings of this inspection had the potential for risk and were attributable to these changes. A stable structure was

necessary to ensure that governance of the centre operated at the optimum effectiveness and efficiency.

The providers policy on formal staff supervisions was not implemented.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider's admission procedures took account of the need to protect residents from harm and abuse. Residents were provided with a contract for the provision of support and services and explanatory information on the services provided and the charges for them.

Judgment: Compliant

Regulation 3: Statement of purpose

The inspector saw that the provider kept the statement of purpose and function under review, updated it as necessary, for example following changes to the management team and made the record available in each house.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on the records seen on inspection the inspector was satisfied that there were adequate arrangements for ensuring that the events specified in the regulations were notified to the Chief Inspector.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The provider was aware of its responsibility and had notified the Chief Inspector of changes and the arrangements for the management of the designated centre with regard to the role of person in charge.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had complaints management policy and procedure that were accessible and utilised as necessary by residents and representatives. Based on the inspectors review of the complaints log, complainants were listened to, if things could have been done better this was acknowledged and concerns were acted on.

Judgment: Compliant

Quality and safety

As discussed in the first section of this report there were unresolved issues that impacted and limited the potential to provide all residents with the best possible support and service that they required in response to their assessed and changing needs. The provider itself was aware of this and had interim arrangements for their management so as to limit risk and impact; long-term solutions were however required.

For example it was clearly established that the design and layout of one house, though of a high standard, was no longer suited to the changing and increasing needs of the residents living in it. Resident needs made it unsafe for them to use the stairs. Controls implemented included the change of use of one ground floor room to a bedroom; this however had removed a recreational space that had been utilised by a resident. In addition while there were ground-floor sanitary facilities these did not support safe or universal access for residents. Consequently to reduce risk and inconvenience for residents, staff were using the ground floor facilities of other residents with their consent or still supported residents to use the stairs with staff assistance and supervision so as to use the accessible bathroom on the first floor. The garden was difficult to access and use due to the lack of appropriate walkways and solid surfaces.

The provider understood and exercised its responsibility to protect residents from all forms of abuse and harm including harm from a peer. Specific recent matters in this regard and their management were discussed. Staff had completed training and the providers reporting procedures were discussed with all new staff as part of their induction. Staff spoken with clearly understood safeguarding matters, knew when residents were displaying signs of being upset and how to protect and support them. Staff and residents discussed staying safe on a weekly basis. Admission procedures reflected the provider's obligation to safeguard residents; there was one

vacant bed in one house based on such a concern.

However there were residents whose needs were not compatible; this incompatibility was one trigger for anxiety that manifested in behaviour of concern and risk to self and others. The provider had management strategies and these included 1:1 staffing from consistent staff that were familiar with and adhered to the behaviour support plan. This adherence was reflected in the narrative notes maintained by staff and observations such as the use of the specified visual schedule. These management strategies had reduced the level of risk and the number of incidents and events but ultimately the matter would not be resolved while residents continued to live together as living together was not suited to the assessed needs of residents.

Staff spoken with had good awareness of residents' rights and restrictions on those rights or residents routines; for example there was good informed discussion on therapeutic and restrictive chemical intervention and the impact of risk management controls on resident privacy and dignity as discussed above in relation to the premises. The inspector saw no evidence of unreasonable restrictions, for example the recorded use of chemical intervention was low and stable. However, how the provider identified, assessed, concluded, agreed and reviewed the restrictive dimension of interventions required for the safety of a resident was not explicitly recorded.

Staff understood each resident's right to have access and control over their monies and personal belongings. Staff maintained a record of resident's personal property and a ledger where each transaction of resident monies was accounted for. There was evidence that oversight was maintained of these records to ensure that resident monies were appropriately managed and safeguarded. Detailed information was provided for residents and their representatives as to what services the provider was obliged to supply and the charge for them. The inspector did recommend that the wording of the contract for the provision of a service should be changed from contribution to charge to more accurately reflect the most recent developments in this regard.

The support and care provided to residents was individualised in that it was based on the assessment of each resident's needs, abilities, risks, wishes and preferences and the plan that was developed based on the assessment findings. The inspector saw that changing needs and the effectiveness of the care and support provided were kept under review and that this review had solid multi-disciplinary (MDT) input. Residents and their representatives were consulted with and participated in decisions about the care and support needed and provided.

The plan of support incorporated each residents personal outcomes measures (POMS); a system to support the delivery of a quality service by establishing and progressing residents wishes and expectations; what is important to them and their quality of life. The inspector saw that 2018 POMS had been progressed and 2019 POMS were in progress. Residents were supported to lead ordinary but fulfilling lives in the community in line with their wishes and capabilities. Residents had opportunity to enjoy travel, to experience work, to learn new skills and to maintain

and develop friendships. Where residents requested or needed a slower pace of life this was facilitated but in a way that ensured residents remained active and engaged with life, family and community.

Residents did have healthcare needs and the inspector was satisfied that staff monitored resident well-being and responded appropriately so that residents enjoyed the best possible health. Again based on records seen much of this care was provided in consultation with and in collaboration with family. Residents had access to a broad range of healthcare services that reflected their assessed and changing needs; some services were available from within the organisational resources. For example the support provided to residents with an increased risk for falls and a history of falls was informed initially by an assessment of risk and then by physiotherapy, occupational therapy, orthotics and falls clinic review. Modifications were seen in practice such as the provision of additional handrails and specific footwear.

This practice reflected the overall role that risk identification and management played in ensuring that resident safety was promoted and protected. Staff spoken with described how risk was identified, assessed and managed; management of risk included input and oversight at the appropriate level of responsibility and escalation to senior management where additional controls were necessary, for example in relation to the unsuitability of the premises as discussed above. The inspector reviewed the risk register and saw that the risks and their management were reflective of resident needs, incidents and events that occurred and the care and support provided. Controls sought to protect residents without placing unreasonable restrictions on their choices, independence and routines. Residual risk ratings reflected the requirement for additional controls; ultimately some residents required ground floor facilities and accommodation to negate the ongoing risk associated with using the stairs.

Staff spoken with had good knowledge of the requirement for safe medicines management practice to protect residents and to promote their well-being. Medicines were supplied by a community based pharmacist known to residents. Medicines were seen to be securely stored and supplied on an individual resident basis. Staff had completed medicines management training and implemented safeguarding systems such as checking medicines when supplied and the stock balance of PRN (as required) medicines. The frequency of the use of these medicines was seen to be monitored at clinical reviews. No resident was managing their own medicines; in the context of residents needs this may have been a reasonable decision; however, the assessment and decision-making pathway was not explicitly recorded.

The provider had fire safety systems that promoted resident and staff safety; it was evident that fire safety requirements informed recent refurbishment works to the premises such as the provision of structures to contain fire and its products and the provision of additional escape routes. Staff had completed training and convened simulated evacuation drills with residents; the drills were completed to simulate different scenarios and while some residents needed prompting from staff, records of drills indicated that the provider had adequate arrangements for their safe and

timely evacuation. Equipment for detecting and fighting fire and the emergency lighting were, based on the certificates seen, inspected and tested at the prescribed intervals.

Regulation 10: Communication

Residents were engaged, informed and eager to communicate. Communication differences were assessed, staff were aware of these differences and any support needed so that residents could communicate effectively such as manual signing was provided. Communication and its role in preventing and responding to incidents of behaviour and risk was recognised in supportive strategies.

Judgment: Compliant

Regulation 12: Personal possessions

There was policy, procedure and practice to ensure the accountable and transparent management of residents personal monies where staff support was required and provided.

Judgment: Compliant

Regulation 13: General welfare and development

From speaking with residents it was evident that residents were supported to live meaningful and fulfilling lives based on their individual skills and choices. Residents had good and meaningful opportunities for community inclusion and integration from participating in community based programmes to enjoying the experience of work. Residents were supported to develop and maintain new and existing friendships and relationships.

Judgment: Compliant

Regulation 17: Premises

The design and layout of one house, though of a high standard, was no longer suited to the changing and increasing needs of the residents living in it. Resident needs made it unsafe for them to use the stairs; this was objectively established by clinical assessment, such as occupational therapy and physiotherapy. These reviews and staff knowledge should inform the type of premises to be provided.

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk management policies and procedures and risk assessments were in place for dealing with situations where resident and/or staff safety may have been compromised. The approach to risk management was individualised and sought to protect residents from known and potential risk while also supporting responsible risk while keeping residents safe from harm.

Judgment: Compliant

Regulation 28: Fire precautions

The provider ensured that there were effective fire safety management systems in place including arrangements for the safe evacuation of residents.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that staff promoted resident safety and well-being by adhering to the providers' policies and procedures on the management of medicines. Staff had completed the training required including training on the administration of emergency/rescue medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were residents whose needs were not compatible. Living together in the designated centre was not suited to the assessed needs of residents and required review.

Judgment: Substantially compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. Each resident had access to the range of healthcare services that they required. Care was evidenced based and informed by clinical review and intervention.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported therapeutically to respond and cope with challenges that presented and were expressed in behaviour of concern or risk. Preventative and response strategies were set out in the behaviour support plan. The plan was informed by MDT input, tailored to resident's individual needs; the effectiveness of the plan was regularly reviewed.

Judgment: Compliant

Regulation 8: Protection

The provider had policies and supporting procedures for ensuring that residents were protected from all forms of abuse. Matters that impacted negatively on resident safety and well-being were recognised and managed.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for No.4 Fuchsia Drive OSV-0004478

Inspection ID: MON-0023382

Date of inspection: 30 - 31/07/2019

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: In March 2019, the PIC & PPIM conducted a full review of the support needs of all persons supported and a new roster was developed to ensure adequate and regular staff with appropriate skill mix to meet the needs of the persons supported in each house. All regular relief staff were interviewed in June and July 2019 to establish their availability to work regular hours on the revised rosters. A new roster is in place since August 18th 2019 that reflects regular, core staff to cater for the current needs of all persons supported. These rosters will be formally reviewed by 30 September 2019 to ensure that they meet the identified needs and represent the best use of resources. Staffing levels/rostering is a standard agenda item on the Leader/PIC monthly meetings.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Training on Records Management to PIC and all House Leaders was delivered on 24th July 2019. Recommendations are in place for removal of duplicate paperwork and for archiving records no longer relevant. The PIC has scheduled individual meeting between the Quality Department and the Team Leaders on an individual house basis to complete this work. The PIC will ensure that the system of tracking recommendations from MDT reviews, Annual Reviews and Provider Visits is streamlined at these record review sessions. The PIC has arranged for that all healthcare management plans to be reviewed by the Community Nurse to ensure they are individual to the person and has arranged for updated self-medication assessments to be conducted and recorded for all residents.	

This work is being overseen by the PIC.
The PIC will ensure that the process of identification, sanction and review of restrictive practices through the Restrictive Practices Committee and option of referral to the Rights Committee is fully documented in the Centre.
The Provider will review the wording of contracts issued to residents to ensure that the charges levied under the Health (Amendment) Act 2013 Residential Support Services – Maintenance & Accommodation Contributions (RSSMACs) are clearly outlined to all residents. The Provider will re-issue contracts to clarify this where necessary.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There is a new PIC in-situ since July 2019 with a month handover period with the outgoing PIC. There is a Full Time Leader in 2 of the 3 houses inspected. In the third house, a Leader transferred in July 2019 but continues to provide support in the interim of recruitment; a new Leader has accepted the Leader role and due to commence on 24th September.

PIC has a schedule in place for the Supervision of all Leaders to be completed by 6TH September 2019. Leaders have a schedule in place for supervision of all staff commencing 9th September 2019. This will continue on a 6 monthly basis for all staff. The PPIM has regular meetings with the PIC and the monitoring of recommendations, and Risk Management of such issues, as appropriate placements/compatibilities, suitability of premises, staffing levels, action plans from recommendations of reviews etc. are part of the PIC/Provider meeting/supervision process.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A number of alternative accommodation options has been identified in the local area. One option is being progressed by PIC/PPIM in conjunction with Facilities Manager in terms of suitable design and layout. The MTD Team and PIC will support this development taking into consideration the needs of the individuals and the overall group. A proposal to acquire alternative premises has been made to the local housing association. Bridging finance is being arranged to support the acquisition of an alternative facility.

A decision on the most suitable option is targeted by 31 October 2019 with the aim to complete the acquisition within a 6 to 9 month timeframe depending on the level of renovation required in the new facility.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Individual and group accommodation needs are regularly reviewed via the Appropriate Placement Forum, in consultation by Leaders/PIC/PPIM/Director of Services and MTD Team.
The accommodation issue has previously been identified via the risk management process; this will be resolved when another group can transfer to a bungalow accommodation that is currently in progress [see Regulation 17 Action plan above]
In the interim period, there are additional support staff, specific protocols and risk management strategies in place to support the needs of the individuals in their current accommodation

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.	Substantially Compliant	Yellow	30/09/2019
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	30/06/2020
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/10/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the	Substantially Compliant	Yellow	30/09/2019

	service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	30/09/2019
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).	Substantially Compliant	Yellow	30/06/2020