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:	No 2 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	04 December 2019
Centre ID:	OSV-0004572
Fieldwork ID:	MON-0025094

About the designated centre

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

No. 2 Seaholly is comprised of three detached, and two semi-detached, bungalows. The number of bedrooms in each bungalow ranges from four to six. Each bungalow has its own garden area. The centre is located on a campus with a number of other designated centres, on the outskirts of Cork city. The centre is registered to provide a residential service to 25 people aged 18 years and older. For the minority of residents this service is provided on a shared care or respite basis. Each resident of No. 2 Seaholly has been diagnosed as functioning within the range associated with a moderate to severe level of intellectual disability. Some residents also have a diagnosis of autism. It is stated in the statement of purpose that each resident requires full support in activities of daily living. The centre is staffed at all times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	20

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
Wednesday 4 December 2019	09:30hrs to 18:30hrs	Caitriona Twomey	Lead
Wednesday 4 December 2019	09:30hrs to 18:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

The inspectors had the opportunity to meet with 12 residents who live in the designated centre. Although a number of residents were unable to communicate their views verbally, the inspectors spent some time in the company of residents and spoke with staff members working in the designated centre.

Residents' body language indicated that they were comfortable in the designated centre. It was clear that staff members knew the residents well, and that they were aware of their individual needs and preferences. Interactions between staff and residents were noted to be respectful, relaxed and unhurried.

During the time that inspectors spent in the houses, two residents had gone shopping in preparation for Christmas and another two were attending their day service, also located on the campus. In one house, all five residents were preparing to go out for a drive with the staff supporting them. Inspectors did not spend any time in one of the houses during this inspection.

Capacity and capability

The number of houses in this centre had reduced by one since the last inspection by the Health Information and Quality Authority (HIQA). Inspectors spent time in four of the five houses that comprise the centre. At the time of this inspection there were five vacancies. Two residents were in receipt of a shared care service. The other 18 people were full-time residents. The number of residents living in the centre had reduced in the previous six months following the move of a group of residents to a house in the community.

At the outset of the inspection, inspectors met with the person in charge. They fulfilled this role for two centres, comprising of six houses. According to the statement of purpose, they dedicated 70% of their working week to this centre and were based on the campus. Each house also had its own dedicated social care leader. The person in charge outlined the arrangements in place for the staff who worked in the centre at night. These staff reported to night supervisors who in turn reported to another member of the organisation’s management team, also based on the campus. As a result, the management structure was such that staff who supported residents at night did not report to the person in charge of the centre.

The person in charge informed inspectors that she completed an audit every quarter of the risk registers in each house that comprises the centre. Six-monthly visits were completed by a representative of the provider in each of the houses. Inspectors reviewed a sample of these in the course of the inspection. An annual review of the

centre was completed in July 2019. This identified that this centre was not appropriate to meet the needs of three residents. The person in charge outlined the plans in place to address this matter. Inspectors were informed that it had been agreed the previous day that one resident will be moving to another designated centre. It was hoped that this would facilitate the creation of a self-contained service for another of the three residents referenced in the annual review. There was no plan in place for the third resident at the time of the inspection.

It was outlined in the compliance plan received following the last inspection that a review of staffing would be completed for all houses in the centre. The person in charge informed inspectors that this was most recently completed in October 2019 and that all units were staffed to meet residents' assessed needs. Inspectors were also advised that staffing was a standing agenda item when the person in charge met with the unit leaders. Despite this, it was reported to inspectors by support staff that the staffing in two houses was inadequate. A staff member reported that staffing in the house where they worked was dependent on the availability of staff from other houses. Following the inspection, the provider informed an inspector that these staff were rostered to move from working in one house in the centre to another. It was documented that on at least 12 occasions in the previous six months the identified staff had not arrived in this house to continue their shift, as planned. In another house, staff spoken with expressed that there had been a recent high turnover of staff but that this had been addressed in recent weeks. Staff in other parts of the centre reported that activities for residents regularly did not go ahead due to staff shortages. At the close of inspection the person in charge outlined that it was their understanding that there was sufficient staffing in the centre and that a number of houses had additional staffing hours available to them.

Inspectors had been informed, through a notification, of the recent discovery that residents' money was missing in one house in the centre. This was the second such incident to occur in this centre since it was last inspected by HIQA. The person in charge outlined measures that had been introduced following the first incident in June 2018. Further safeguarding measures had been introduced following the more recent incident in October 2019. These included that the safes to be used for residents' finances are now stored in locked cupboards. The provider had refunded all residents who had been impacted by these events.

The person in charge outlined the training identified as mandatory for the staff team working in the centre. A variety of additional training courses that were available to staff were also outlined. These included some that were specific to individual residents and others that were related to residents' assessed needs. At the time of the last inspection, a new system was being piloted to try and address staff training needs in a timely manner. The person in charge advised inspectors that this approach had not continued past the pilot phase. Training records for 41 staff were provided to inspectors at the feedback meeting. These records were reviewed following the inspection. Records indicated that, with the exception of fire safety (required by 12% of staff) and safeguarding (required by 15% of staff) training, over 55% of the staff team had either not attended mandatory training or it had expired. These high figures were in part due to the practice, as identified in the last inspection of this centre, of staff attending refresher sessions when, due to

the time that had passed since they last completed the full training, a repeat of the full training course was required.

From the sample reviewed it was identified that improvements had been made in the centre since the last inspection regarding the written agreements provided to residents, and where appropriate their representatives, regarding the service to be provided in the centre. While not all agreements had been signed, there was evidence that the provider had continued to follow up on this matter.

Regulation 15: Staffing

There was evidence that the number of staff working in the centre was not appropriate to the number and assessed needs of the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

There was evidence that regular training was provided to staff working in the centre however the number and frequency of sessions provided was not sufficient to ensure that staff's mandatory training was maintained. It was also identified that staff attended refresher sessions when the full training session was required.

Judgment: Not compliant

Regulation 23: Governance and management

It was not demonstrated that the management systems in place ensured the service was appropriate to residents' needs. The management structure in the centre did not ensure that all staff providing direct support to residents were accountable to the person in charge of the centre.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider and person in charge met the requirements of this

regulation.

Judgment: Compliant

Regulation 3: Statement of purpose

It was identified that the floor plans included the statement of purpose did not accurately reflect the primary function of some rooms in the centre. The management structure in the centre regarding staff who provided support at night was not reflected in the statement of purpose.

Judgment: Substantially compliant

Quality and safety

Overall, the centre was observed to be clean and decorated in a homely manner. When spending time in the various parts of the centre, it was identified that maintenance was required. This included areas that required painting and furniture that required repair or replacement. It was identified that a previous inspection finding, that the laundry areas were inaccessible to residents, had not yet been addressed by the registered provider. It was also identified that in many parts of the centre there was not a suitably private area for residents to spend time with visitors.

Inspectors reviewed the fire precautions in one of the houses. There were a number of issues identified that did not assure inspectors that the centre was in compliance with the regulation regarding fire precautions. Some of these related to the containment arrangements in the centre. For example, not all fire doors were fitted with an automatic self-closing device, damage to seals on fire doors was observed and gaps were evident when the doors were closed. On the day of the inspection, maintenance personnel were working on the campus to address issues with fire doors. It was demonstrated to inspectors that these planned works would incorporate this centre. In addition to the issues with fire doors, it was identified that some of the designated fire escapes were not accessible to residents, and that the paths to the assembly point from these exits were also not accessible to all residents living in that part of the centre. An inspector reviewed fire drill records. Four drills had been completed in the previous 18 months. This was not in keeping with the organisation's own policy that a minimum of four drills be undertaken annually. It was reported in one record reviewed that one resident was uncooperative during the evacuation. The extra support provided by staff appeared effective as an evacuation time of less than two minutes was recorded. Each resident had their own personal emergency evacuation plan (PEEP) that had been

reviewed within the previous six months. There was also a night-time procedure for evacuation. The information in this document was not consistent with the support guidelines outlined in the individual PEEPs. An inspector spoke with a staff member about evacuating the centre while residents are in bed. This staff member advised that those drills are completed by night staff, although not all residents are up and out of bed when the day shift begins in the morning. Inspectors were also concerned that some bedrooms may constitute inner rooms. When visiting other houses in the centre, some of the same issues were identified. Given the extent of the issues identified, the inspectors requested that a competent person conduct a comprehensive review of fire safety in all five houses that comprise the centre. A letter to this effect was sent to the provider on 17 December 2019.

Staff appeared to have a good understanding of residents' individual communication styles and preferences. Residents had recently reviewed communication passports in place. It was identified in the course of the inspection that there was not adequate access to the internet for residents. Although, as was outlined in the annual review, Wi-Fi was now available in the centre, staff reported that the signal was not reliable or accessible in all parts of the centre. This was of particular significance to residents who wished to use the internet to maintain family contact and for recreation purposes. Staff also had a very good knowledge of residents' nutritional needs, especially where they were assessed as requiring a modified diet.

The inspectors were aware prior to the inspection that the service provided to one resident was under review. During the inspection, the person in charge advised that this review was underway for all three residents living in one of the houses and was being completed by various multidisciplinary professionals employed by the provider. The review commenced in May 2019 and at the time of inspection, December 2019, was not yet completed. As a result, a multidisciplinary review of these residents' plans had not been completed in the previous 12 months, as is required by the regulations. A document outlining the terms of reference and review process, written by one of the team completing the review, was provided to the inspectors. This stated that the expected completion date for the report was the end of February 2020. There was an identified high risk of injury to both residents and staff in this house. The person in charge advised that one preliminary recommendation was that an alternative accommodation service be sourced for one of the residents. This recommendation was discussed at the meeting of the admission, discharge and transfer committee the previous day and while another designated centre had been identified there was no established timeline for the move.

One of the terms of reference of the review was to provide feedback on the frequent use of seclusion in this house. On the day of the inspection, it was identified that in the previous three months, one resident had been subject to seclusion on 52 occasions. Staff informed an inspector that this person attended a day service where there were no facilities for seclusion. An inspector reviewed the guidelines for staff regarding how to respond when the person began to show signs that they may engage in behaviours that challenge. This document included the guidelines for the use of seclusion. It was identified that this document was dated October 2017. Two staff confirmed to the inspector that these were the guidelines they implemented when supporting this resident. At feedback the person in charge

informed inspectors that these guidelines had been reviewed more recently. Guidelines for staff on how to interact with this resident were dated January 2015. There was evidence in the house that regular review meetings, attended by staff working in the centre and multidisciplinary professionals, were held to review the support this person received in the centre. Given the continued high rate of use of this restrictive practice, and the identified high risks of injury it was positive to hear that an alternative placement had been identified that it was hoped would better meet the needs of this resident. There were no reported uses of chemical restraint in the centre.

Inspectors reviewed a sample of residents' files. There was strong evidence to support that residents' healthcare needs were well met in the centre. Residents had regular access to a general practitioner who regularly visited the campus. There was evidence that residents were referred to, and supported to attend, allied health professionals and specialists as required. It was identified in one house that guidelines for the administration of PRN medications (medications only taken as required) had not been reviewed in the last 12 months. There was also some uncertainty in this document regarding when to administer the second line of medication. The document stated that the time required between administrations of each medication was 'up to 15 minutes'. However the staff spoken with advised that they were required to wait at least 15 minutes before administering the second medication. This resident was regularly reviewed by their treating psychiatrist, with the most recent review taking place the day before the inspection.

Inspectors reviewed a sample of residents' personal plans in a number of the houses that comprise the centre. Of the sample chosen by inspectors, all residents, with the exception of one, had been supported to develop a personal plan in the previous 12 months. It was outlined by the person in charge at the opening of the inspection that this area required improvement in the centre. Inspectors' findings were consistent with this assertion. In many cases goals appeared to be linked to everyday activities rather than individualised goals for the resident in question. Examples of goals included a resident to attend their scheduled activities, and for staff to become familiar with a resident's support plans. In other cases it was identified that goals were repeated from the previous year. It was identified for a number of residents that the timeline for the completion of goals was vague or undefined. In the sample reviewed, there was no evidence that residents' representatives were invited to participate in the development of personal plans. The reviews held regarding the progress made in residents achieving their goals also required improvement. Often these reviews did not provide an update on the specific goals. For example, part of a goal for one resident was to use Skype to communicate with a relative. There was no update regarding this when the goal was reviewed, although details of other family contact were included. Other reviews made reference to residents being encouraged to do things but it was not clear if they had participated or not. On other occasions, opportunities to achieve goals appeared short-lived. It was a goal for one resident, who did not attend a day service, to go swimming in the pool located on the campus. This goal was developed in April. In July, it was stated in the review documentation that this would begin in September. Another review was completed at the end of October. This outlined that for several weeks, the resident had enjoyed swimming but that due to limited

availability of time in the pool this had now stopped.

A sample of activity records for residents were also reviewed by inspectors. These demonstrated that the majority of activities for residents were in their homes and if outside, they were most often campus based. The most frequent activities noted for the residents of three houses were to go for a walk on the campus or for a trip in the car. When these journeys were discussed with staff in one house, they advised that for the majority of occasions, including when the purpose of the journey was to do shopping, residents remained in the car. There were noted outings where residents went for lunch in a local shopping centre however these occurred less frequently than the other journeys recorded. Each resident had an activity schedule for the week but the daily records reviewed indicated that these schedules were often not implemented as outlined. It was not noted in the records why an activity may not have happened. Another resident wished to attend a day service. A local option had been explored, however due to the resident's mobility support needs this service was not physically accessible to them. There was no documented plan to support this resident to attend a day service suitable to their assessed needs. It was also noted that were examples where residents were being successfully supported to achieve their goals. Increasing family contact was a theme across the sample of plans reviewed and there was evidence that progress was being made in achieving this goal.

Regulation 10: Communication

Staff were observed to have a good awareness of residents' individual communication styles. Wi-Fi internet access was introduced to the centre in 2018. Staff in some houses reported that the quality of this varied and at times was not available. As a result some residents were no longer using the internet to maintain relationships with family members.

Judgment: Substantially compliant

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. It was identified that in some parts of the centre a suitable private area was not available to residents to meet with their visitors.

Judgment: Substantially compliant

Regulation 13: General welfare and development

There were not appropriate opportunities and supports for residents to participate in activities in accordance with their interests. It was identified that the majority of residents' activities were based on the campus, limiting opportunities to develop and maintain relationships and links with the wider community.

Judgment: Not compliant

Regulation 17: Premises

The premises were observed to be clean. Areas that required repair and maintenance were identified. It was also identified that not all parts of the centre were accessible to the residents that lived there.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The person in charge met the requirements of this regulation.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider was asked to arrange for a competent person to conduct a comprehensive review of fire safety in all five houses that comprise the centre. This was requested following concerns identified with the containment and evacuation arrangements and the means of escape in the centre. It was also identified that fire drills and staff training in fire safety were not completed at the frequency outlined in the organisation's own policy.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

As was outlined in the centre's annual review, the designated centre was not suitable for meeting the needs of each resident in the centre. It was identified that many residents' personal plans did not outline the supports to

maximise their personal development in accordance with their wishes. In the sample reviewed, the participation of residents, or their representatives, in the development and review of their plans was not documented. Not all residents had multidisciplinary input into the review of their personal plans in the last 12 months, as is required by the regulations.

Judgment: Not compliant

Regulation 6: Health care

Overall residents' healthcare needs were well met in the centre. One document viewed by inspectors had not been reviewed in the previous 12 months and required revision to ensure that the guidelines were accurate and clear.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Although there was evidence of regular review of the supports received by residents who at times engaged in behaviours that challenge, this was not reflected in the documents available to the staff team directly supporting the person. It was identified that where used, the consent of the resident or their representative regarding the use of closed-circuit television (CCTV) was not documented.

The findings regarding staff training, as required by this regulation, were included in the findings relating to the regulation on training and staff development.

Judgment: Substantially compliant

Regulation 8: Protection

A sample of safeguarding plans were reviewed. The provider and person in charge were found to meet the requirements of this regulation.

The findings regarding staff training, as required by this regulation, were included in the findings relating to the regulation on training and staff development.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 11: Visits	Substantially compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for No 2 Seaholly OSV-0004572

Inspection ID: MON-0025094

Date of inspection: 04/12/2019

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 Person in Charge will ensure that the Services staffing procedures are fully implemented in all areas at the Centre i.e.
• On a quarterly basis, the staffing budget is reviewed with the Person in Charge and Financial Manager and appropriate actions are put in place to support each resident in terms of resources.

• The person in Charge carries out quarterly staffing audits of all of the properties in No.2 Seaholly this includes staff skills mix audits to ensure that the staff's skills are adequate to meet the assessed needs of the residents they are providing direct support to.

• Where nursing support is identified as required it is provided.

• The Person in Charge holds regular team meetings with the Social Care Leaders to identify any staffing requirements they may have and recruits accordingly. Note this system has delivered on the following supports: -
• September 2019 meeting identified 2 general relief staff were required to support No.2 Seaholly these staff are in post and actively working.

• October 2019 meeting 1 relief staff required for 1 property, this post was recruited.

• There were no Permanent vacancies at the date of inspection 04.12.19

• Copies of the house rosters are held with the Person in Charge and the staffing compliment is in line with the details on the Statement of Purpose.

• Staffing budgets are created annually with the Person in Charge and Finance Manager taking into account any change in need as advised by the Person in Charge. The 6 monthly unannounced inspections indicate that staffing levels are sufficient in No.2

Seaholly.

• The PIC has revised rosters with Social Care Leaders to ensure staff were rostered on duty at times to meet the needs of the residents including to enable increased community access in the evenings.

• The Person in Charge will ensure that Staff Team Meetings provide the forum to update the Person in Charge in relation to:
- concerns on staffing levels
- details of planned activities that did not do ahead due to staffing issues
- details of roster commitments not filled due to staff re-assignment to other areas in the Centre
- identification of resources allocated but unused since the previous meeting

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person in Charge will ensure that staff trainings are identified and planned for on a timely basis i.e.

• The person in Charge issued a training tracking form to all Social Care leaders on 18/12/19, this will be populated by the Social Care Leader and will assist with bookings and identifying training requirements. The mandatory trainings are clearly highlighted, showing the date training took place the timeframe for refresher and when refreshers are due/planned. This will be monitored by the Social Care Leader and the PIC to ensure that full or refresher training requirements are correctly identified.

• The training Department is now issuing training dates quarterly (introduced in January 2020) to support the booking of mandatory trainings.

• The training department will provide additional training dates for No.2 Seaholly where they have been identified as required.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and

management:
The system of Governance and oversight includes the following controls to effectively monitor the care and support provided in the centre:

• A new staffing system has been put in place by the Person in Charge. All staff working in each of the houses report directly to the Front Line Manager/Team Leader who in turn reports to the Person in Charge covering the twenty-four hour service i.e. day and night staff
• The person in Charge in based on site and makes regular visits to all of the houses in No.2 Seaholly.
• The Person in Charge carries out quarterly audits on Restrictive practices in use in the Centre, Risk register audits and staffing skills mix audits.
• The person in Charge holds regular meetings with the Social Care Leaders and Night Supervisors with set agenda and minutes provided to all staff following the meetings.
• The Person in Charge receives a weekly service area report of significant issues.
• The Person in Charge attends all Annual Multi-Disciplinary review meetings, restrictive practice sanctioning and review meetings.
• Regular meetings are held with the PPIM and Director of Services in relation to compliance.
• 6 monthly unannounced visits are in place and actions are clearly defined, the Peron in Charge works with the Social Care Leader to ensure actions are time framed and implemented.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose and function will be updated to reflect the current function of rooms in the Centre.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• Staff demonstrate a good awareness of resident's individual communication styles and total communication environments are in place.

• The IT service desk was established in 2017 to resolve any IT issues that are reported in a timely manner. The PIC met with the Social Care Leaders following the inspection to identify in which areas residents were no longer using internet to maintain relationships

with family, no such areas were identified and this has never been reported to the Centre's service desk. It was identified that a family member residing abroad requested telephone contact weekly rather than use Skype as their IT equipment is aging and unsuitable for Skype. These weekly telephone conversations occur every Saturday.
• Assistive technology is in place for some residents to promote choices and maintain links with family.

• Issues have been reported with the Wi-Fi signal in 2 properties and the service desk system is utilised to report same. A member of the Information Technology department will attend a Social Care Leaders meeting on 12/02/20 to demonstrate to staff how to re-boot the system.
• A new 3G mobile connection will also be trialed.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
• As referenced in the Statement of Purpose and function the houses are based on ordinary residential living, visitors are generally received to the sitting room areas. Staff ensure that any resident who receives a visitor is given time and privacy for the duration of their visit with least disruption to the other residents.
• A room in a facility adjacent to the residence will also been identified for private family visits if so requested.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• A person Centered planning facilitator commenced in post in December 2019. The role includes actively supporting the Social Care Leader and Key workers in setting SMART goals for residents and updating weekly schedules/timetables that are in place for our residents to include community integration activities.
• The Person in Charge will continue to ensure that day service options are explored for residents who have significant sensory support needs in line with their PCP
• Access to transport was increased in 2019 with the introduction of Taxi usage for some residents once risk assessed as safe to do so. An additional vehicle was also introduced in 2019 to enable increased external activities.
• The PIC revised rosters with Social Care Leaders to ensure staff were rostered on duty at times to meet the needs of the house including to enable increased community access

in the evenings. • All residential houses have access to transport in the evenings.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • To Comply with Regulation 17 the services carry out annual audits of what repairs are required to be completed in the coming year. This information is sent to the Facilities Manager and works are scheduled accordingly. This information was identified at a meeting on 08.01.2020. The facilities manager has scheduled the maintenance works to be completed by 30 June 2020 and enhancement works to be completed by 30 September 2020. • The PIC will ensure that the maintenance logs are kept updated in each area and that delays are followed up where necessary. • The PIC will seek an Occupational Therapy recommendations in relation to supports to residents with significant health support needs in accessing laundry facilities in the Centre.	

Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • A report from the Service appointed competent person has been completed and sent to the Authority. • The Services have committed to engaging an external consultant to report on fire compliance issues. This report will involve a comprehensive review of fire safety in all five houses that comprise the centre to include a Fire Safety Risk Assessment. • The Person in Charge and the Team Leaders have ensured that the night time evacuation protocol and the PEEPS are consistent in their approach. • Two unannounced evacuations have been carried out since the inspection took place and the Person in Charge has scheduled early morning evacuations by day staff when residents may still be in bed. • The Provider will ensure that the Fire Compliance Building Works Plan 2019 is progressed and finalised for the Centre by 31 August 2020. • Fire doors requiring repair were completed by 12.12.19. The provider will ensure that inspection of fire doors forms part of the Centres routine weekly inspections in the Centre. • The Provider will request the opinion of the external consultant in relation to fire doors which are not accessible by wheelchair users i.e. are these required or are current alternative exits sufficient under Regulations.	

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The service compiles a Training Needs Analysis on a yearly basis as part of the training for the implementation of Person Centred Planning i.e. Key Worker Training and POMS Training. The Person in Charge has organised further training for all the staff through the Quality and Training Department.
• A person Centered planning facilitator commenced in post in December 2019. The role includes actively supporting the Social Care Leader and Key workers in setting SMART goals for residents. Work commenced on this in this Centre on 28.01.2020
• All residents in the centre have an individual assessment and personal plan[PCP]
• The Person In Charge will ensure that residents are encouraged to participate, as far as possible, in the development and review of their personal plans.
• The PCP system provides for regular review of the progression of goals and this will include a review of the progression of day service activity.
• The annual multi-disciplinary review meetings ensure there is clinical oversight on the goals set for residents.
• The Provider, PPIM and PIC have agreed alternative locations for two inappropriate placement and have put in place a structure to flag changing need and high risk placements for future planning.
• A full multidisciplinary review of the suitability of the placement for a third resident flagged as a possible inappropriate setting is being scheduled by the PIC. The recommendations from this review will be considered for future planning as necessary by the Services Appropriate Placements Oversight Committee [30 June 2020].
• An updated Personal Outcome Measures report on the personal plans was sent to all houses on the 28.01.2020.
• Multi-Disciplinary review of the personal plan meetings have been scheduled for all houses in the Centre for 2020 and will all be completed by 28.05.2020.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• A general Practitioner is on site twice weekly. A dentist visits fortnightly.
• Residents are supported to attend allied health professional and specialists as required.
• The Person In Charge will ensured that all PRN protocols are reviewed to ensure that these are accurate, clear and up to date.

• The Person in Charge will ensure that these protocols are kept updated and that a quarterly audit is conducted on same.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• Consent for the use of closed-circuit television has been requested from the Director of Services and will be documented on file in the house.

• The interaction protocol for 1 resident dated 2015 will be marked as reviewed and current. This protocol is a guideline for staff on how to best interact with the person to meet their development needs. The date on the document is the date it was written, these recommendations remain valid and the implementation of these recommendations is discussed with staff on an ongoing basis at scheduled meetings.

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 10(3)(a)	The registered provider shall ensure that each resident has access to a telephone and appropriate media, such as television, radio, newspapers and internet.	Substantially Compliant	Yellow	28/02/2020
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	11/12/2019
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and	Substantially Compliant	Yellow	31/03/2020

	recreation.			
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	31/03/2020
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	31/03/2020
Regulation 13(4)(a)	The person in charge shall ensure that residents are supported to access opportunities for education, training and employment.	Substantially Compliant	Yellow	30/06/2020
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	Not Compliant	Orange	11/03/2020

	centre.			
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	05/06/2020
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/09/2020
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	30/06/2020
Regulation 17(7)	The registered provider shall make provision for	Substantially Compliant	Yellow	30/06/2020

	the matters set out in Schedule 6.			
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	14/12/2019
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.	Not Compliant	Orange	12/02/2020
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	12/02/2020
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in	Substantially Compliant	Yellow	27/03/2020

	place.			
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.	Substantially Compliant	Yellow	27/03/2020
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	27/03/2020
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	27/03/2020
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	27/03/2020
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 to safe locations.	Not Compliant	Orange	27/03/2020
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency	Substantially Compliant	Yellow	23/04/2020

	procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	27/03/2020
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	31/03/2020
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in	Substantially Compliant	Yellow	28/02/2020

	need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/06/2020
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	10/02/2020
Regulation 05(4)(c)	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 is developed through a person centred approach with the maximum participation of each resident, and where appropriate his or her	Not Compliant	Orange	10/02/2020

	representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	28/02/2020
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Yellow	30/07/2020
Regulation 05(6)(c)	The person in charge shall ensure that the	Not Compliant	Orange	30/07/2020

	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.			
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	31/03/2020
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	31/03/2020
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	05/06/2020
Regulation 07(2)	The person in charge shall	Substantially Compliant	Yellow	05/06/2020

	ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	14/02/2020
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Substantially Compliant	Yellow	22/05/2020
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the	Substantially Compliant	Yellow	22/05/2020

	shortest duration necessary, is used.			