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

Issued by the Chief Inspector

Name of designated centre:	No.3 Stonecrop
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	25 September 2019
Centre ID:	OSV-0005146
Fieldwork ID:	MON-0023911

About the designated centre

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

No.3 Stonecrop provides residential supports for a maximum of five female adults. Support is provided to people diagnosed with a mild, moderate or severe intellectual disability, including those with autism. Each resident of No.3 Stonecrop requires support in activities of daily living. The focus in the centre is meeting the individual needs of each person within a homely environment.

The centre is a semi-detached, two storey house in an inner suburb of Cork city. Each resident has their own bedroom. There is a communal kitchen and living room area in the house. There are also garden areas to the front and rear of the property. There are two staff rostered to work in the centre every afternoon until 10pm, with one staff sleeping in the centre overnight.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 25 September 2019	09:15hrs to 18:10hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

The inspector met with all five residents living in the centre. The majority of residents were verbal communicators and appeared happy to meet with the inspector. Overall the residents were very positive about living in the centre. Residents spoke about what they liked to do with their time, recent activities and things that they were looking forward to. A resident spoken with was clear on who to speak with if they were not happy about something in their home, and told the inspector that they were happy with how any matters they did bring up were addressed. Residents in the centre each had allocated household tasks and some were seen completing these jobs. It was evident that each resident had strong relationships with family members and that these relationships were very important to them. It was clear that some residents were very independent and that this was both important, and a source of pride, to them. On the morning of the inspection two residents left the centre together to walk to their day service.

All of the residents appeared at ease in their surroundings and with the staff on duty throughout the day. The inspector observed an interaction between two residents where one expressed unhappiness at another telling them what to do. Staff informed the inspector that this was not unusual. It was also noted that some communal areas such as the hallway and kitchen were at times crowded and required that staff and residents move out of each other's way to carry out their daily activities.

On the day of inspection residents and staff were celebrating one resident's birthday. All appeared excited about this celebration and participated in the preparation in different ways.

Capacity and capability

The oversight of the support provided and the experience of residents living in the centre required significant improvement to ensure the service provided was safe, consistent and appropriate to residents' needs.

A new person in charge had been appointed since the last inspection of the centre in November 2017. This person fulfilled this role for four centres, comprising of six houses. According to the statement of purpose, they dedicated a fifth of their working week to this centre. There was a full-time social care leader working in the centre who was absent on the day of the inspection. When asked who was completing the roles and responsibilities of the social care leader in their absence, staff were not clear. One staff member advised that they had taken responsibility for

managing the staff roster. Later when reviewing fire safety documentation, it was identified that weekly fire checks had not been carried out in the social care leader's absence. These findings indicated poor management systems in the centre which did not account for unexpected absences of key staff and the reallocation of their roles and responsibilities.

When asked, the person in charge advised that there were no open complaints in the centre. On review of the complaints log it was identified that there was no documented follow up to the majority of complaints recorded in the centre. All of the complaints recorded had been made in 2018. Dissatisfaction with the size of the centre and the compatibility of the residents living there were recurrent themes. In the one instance where the follow up actions were recorded, the response to one resident's complaint regarding the presence of relief staff in the centre was to support them to cope with this situation. While this demonstrated the provision of appropriate individualised support, the focus of the complaint was not addressed or escalated through the complaints process. In addition, staff and the person in charge had spoken with the inspector about two residents voicing their dissatisfaction about the impact on them of living with another resident. This matter was not included in the complaints log. It had been identified in the two most recent six-monthly visit reports completed by a representative of the provider that complaints documentation in the centre needed to be addressed.

The compatibility of the resident group and the size of the premises had been raised during the last Health Information and Quality Authority (HIQA) inspection of this centre in November 2017. At that time the person in charge had committed to keeping these issues under review. Since then, there had been a change in the personal circumstances of some residents meaning that they now spent more time in the centre, there were complaints linked to these issues, and there were a number of incidents between residents that resulted in the development of safeguarding plans. A letter written by a psychologist regarding one resident also stated that their residential placement was not appropriate. It was documented that these issues had been topics of discussion at some of the residents' multidisciplinary review meetings however the discussion had, or any plans proposed to address them, were not recorded. It was therefore not clear, what if any, plans the provider had in place to address these long identified issues.

On review of the staffing rosters it was noted that a large number of relief staff had worked in the centre. There was evidence to suggest that this had a negative impact on residents. The use of relief staff featured in a complaint made by one resident and was also central to some documented incidents in the centre. The person in charge confirmed that a fourth permanent staff member had recently been appointed to the house and spoke about the challenge of allocating staff to the centre as a result of unexpected absences. This challenge had also been reported by staff who spoke about working additional hours some weeks to lessen the impact to residents of being supported by people they did not know. The inspector reviewed a folder of information compiled to support relief staff working in the centre. The resident profiles in this folder were last reviewed in November 2017. The support needs of residents had changed in this time. Safeguarding plans had also been developed for a number of residents. These were not available in this folder or in

residents' individual files. These findings demonstrated poor continuity of care for residents and poor oversight of systems in place to minimise the impact of this on residents.

It was noted on a document completed by the designated officer that one resident living in the centre received one to one staffing support. At times there was only one staff member rostered to work in the centre. Additional staff had been appointed to the centre, four mornings a week. HIQA had been advised of this intervention following the notification of an adverse incident. Staff outlined that on one other morning a week the social care leader often spent time in the centre as a second staff member. There was no such additional staffing support at the weekend. In addition, following other adverse incidents staff were advised to be extra vigilant and to provide additional supervision of other residents. It was not demonstrated that these assessed needs could be met with the rostered number of staff in the centre.

On the morning of the inspection a staff member spoke with the inspector about a recent alleged incident of abuse in the centre. The staff member clearly outlined the steps that had been taken to address this issue. Although this incident had been documented the previous week, it had not been notified to HIQA, as is required by the regulations. The person in charge was aware of this incident and that the required timeframe for notification had passed. Since the last inspection notifications had been submitted regarding allegations, suspected or confirmed, of abuse of residents. On review of the documented incidents in the centre, the inspector identified a number of other similar incidents that had not been notified to HIQA. This was consistent with findings of the previous inspection.

The inspector reviewed the annual review of the centre and the two most recent six-monthly visit reports completed by a representative of the provider. The annual review included an improvement plan that outlined objectives relating to storage of documentation, regular review of residents' files, staff supervision and the completion of fire drills. On the day of inspection the person in charge also outlined a plan to modify the upstairs staff office to create another communal space for residents. It was hoped this would be completed within the following month. This plan had been developed in recognition of the challenge posed by the limited space in the centre. There was no evidence of consultation with residents or their representatives in the annual review, as is required by the regulations.

The two six-monthly visit reports were completed in October 2018 and April 2019. They were comprehensive and identified a number of the issues identified again during this inspection. These included reference to the installation of magnetic door closures to facilitate fire doors being kept open safely, the size of the property, the low level of detail in fire drill records, a recommendation to store safeguarding plans in residents' files, the need to follow up on complaints, and the need to review residents' files in line with prescribed timeframes. That these issues were all identified in the course of this inspection indicated that the action plans generated from the six-monthly visits were not fully implemented.

Given the number of not compliant findings identified during this inspection and

their significance, it was not demonstrated that the provider could ensure the effective governance, operational management and administration of this designated centre.

Regulation 15: Staffing

The number of staff was not appropriate to the number and assessed needs of the residents. A large number of relief staff had also worked in the centre in recent months. The documents specified in Schedule 2 of the regulations were not reviewed as part of this inspection.

Judgment: Not compliant

Regulation 23: Governance and management

Management systems in the centre were not effective in ensuring the service was safe, appropriate to residents' needs and consistent. The oversight provided did not ensure that the service provided in the centre was effectively monitored. The centre was not sufficiently resourced to deliver the support required by residents. The annual review did not provide for consultation with residents and their representatives. Although comprehensive, the six-monthly visits did not result in the full implementation of plans to address the standard of care and support in the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The staffing hours for the centre reported in the statement of purpose were not the same as those outlined on the roster in the centre. It was also noted that rather than No.3 Stonecrop the names of other designated centres were referenced at times in this document.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge did not notify HIQA of adverse incidents occurring in the

centre, as is required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was no evidence that the majority of complaints had been investigated, the complainants informed of the outcome, or measures put in place in response to complaints. The record of complaints in the centre was not maintained.

Judgment: Not compliant

Quality and safety

From spending time with residents and staff it was evident that the support provided in the centre was centred on meeting each resident's individual needs. However, poor implementation and oversight of the systems in place resulted in residents not receiving the standard of support they deserved to lead as fulfilling a life as possible. As will be outlined later in this report, improved implementation of the policies and procedures relating to risk management, safeguarding and fire precautions was required to ensure that the service provided to residents was safe.

The inspector reviewed a sample of residents' files. There was no record of recent multidisciplinary reviews. The person in charge assured the inspector that these had occurred and later provided the records of the meetings held six weeks previously. In the records seen by the inspector no one was assigned to follow up on the recommendations made at these reviews. It was also noted that residents had not attended their own review meetings. On review of other documents in residents' files it was noted that many had not been reviewed in the previous year, as is required by the regulations. Examples of plans not reviewed included information to inform daily support, a behaviour support plan and a communication passport.

There had been input from behaviour support specialists into a resident's plan since the last inspection. It was also identified that a review of restrictive practices in the centre had resulted in two environmental restrictions being removed. On review of documented incidents in the centre it was identified that PRN medication (medicine administered only as required) was at times administered to one resident during incidents of behaviours that were challenging.The use of these medications was included in a healthcare plan. The guidelines for the administration of this medication were also included in this resident's reactive strategies, which formed part of their behaviour support plan. It was also noted on the resident's medication administration record and prescription sheet that the medication was to be

administered as required for agitation. This combined evidence resulted in the inspector concluding that this medication was a form of chemical restraint and as such its use should be notified to HIQA, as is required by the regulations. Following the inspection, the provider submitted documentation, signed by the resident's treating psychiatrist, that provided evidence that the administration of this medication did not constitute chemical restraint.

The residents in the centre were very familiar with their local community and regularly accessed shops, restaurants and other local services. Some of the residents were very independent in many areas of their lives and all residents sought to further their independence through the personal planning process. Each resident in the centre was supported to develop their own goals to achieve throughout the year. These goals reflected residents' wishes to be more independent, to learn new skills and to develop roles in their local community. It was difficult to assess how residents were being supported to achieve these goals. The information recorded regarding these reviews was not specific and it was not documented why goals had not progressed or been achieved. For example, one resident wished to independently use the public bus to go to Cork city. Almost one year later this goal had not been achieved, despite the fact that the resident was independently using the bus to go to the city from their family home at the time this goal was developed. In addition, some goals comprised a number of related goals, however not all of these were mentioned in the review documentation. The process outlined in the documentation indicated that goals were to be developed annually and reviewed quarterly. In the sample reviewed by the inspector, one resident's goals had not been reviewed in eight months and another two residents' plans were most recently reviewed six months previously. For one of the residents it was over a year since their plan had been developed and as such new goals should have been developed by the time of this inspection.

Residents' healthcare needs appeared well met in the centre. For each identified health issue there was a corresponding healthcare management plan. The sample of these plans reviewed by the inspector had been reviewed recently. There was evidence of recent medical appointments including check-ups for residents. Staff appeared knowledgeable about each resident's healthcare needs and supported residents to attend appointments, when necessary.

It was identified during the last inspection that one resident and the staff team required additional support in the area of communication. During this inspection, there was evidence of input from a speech and language therapist in this resident's file and three permanent staff had attended training in the use of Lámh (a manual sign system used by people with an intellectual disability and communication needs in Ireland). In the course of this inspection the use of the recommended communication supports was not observed. It was also identified that the relief staff working in the centre had not received this training, including those that provided one to one support to this resident. At the front of this resident's file there was a document titled 'Things you must know about me', this included no reference to the use of Lámh or the other recommended communication supports.

The inspector reviewed the risk register for the centre. The register had recently

moved from a paper-based to an electronic record. It was evident that the risk register required review. Many risks on the register did not have any rating. Risks that had been entered in July 2017 remained on the register. Although the details of these risks had changed, this was not reflected in revised risk ratings. It was also identified that the impact and likelihood scores of some risks did not reflect the current situation. Other hazards identified during the inspection, such as the size of the centre and the incompatibility of some residents, were not included on the register.

It was identified on the previous inspection that staff were not clear on what constituted abuse. As a result of this finding the organisation's designated officer had met with the staff team to complete a workshop on safeguarding issues. Staff spoken with reported that they had found this helpful and that it had informed the way they now thought about incidents in the centre. The system in place, as reported to the inspector, was that suspected or confirmed allegations of abuse were recorded on a specific form and when completed, staff alerted the person in charge. The person in charge then contacted the designated officer and made any required notifications to HIQA. Where assessed as appropriate, the designated officer, person in charge and members of the staff team then collaboratively developed a safeguarding plan. Other incidents in the centre were recorded on a different form. These were routinely reviewed and signed by the person in charge.

On review of records, the inspector identified a number of incidents that may constitute abuse that were not recorded on the specific form and were not subsequently notified to HIQA, as is required by the regulations. As well as staff not recognising that these incidents may constitute abuse, this was also not identified by the person in charge when signing the records of these incidents. As a result the inspector concluded that there continued to be a lack of clarity, and oversight, regarding what constitutes abuse in this centre. The impact of this was that the extent of the safeguarding concerns in the centre was not known to the designated officer or escalated to the provider.

From notifications submitted to HIQA, the inspector was informed that there were safeguarding plans in place for two residents. On the day of inspection only one safeguarding plan was documented in the centre. When speaking with staff they were able to outline the supports they implemented to keep residents safe and to reduce the likelihood of negative interactions between them. As outlined when discussing staffing in the Capacity and Capability section of this report, it was not evident that these plans could be implemented with the number of staff working in the centre.

The house was decorated in a homely manner and was clean throughout. Residents' bedrooms were decorated in line with their preferences and reflected their interests. The living room was comfortable and decorated with photographs of the residents. When walking through the property it was identified that some walls needed to be repainted and in other areas replastering was required. The back garden was untidy and the seating provided was in poor condition.

As the inspector walked around the centre, it was observed that fire doors were

routinely kept open in the house using furniture and in one instance a door wedge. As a result of this the containment measures in the house were ineffective. In addition, one of the doors in the kitchen required review by a competent person to provide assurance that the door would be capable of restricting the spread of fire and smoke. There was a fire exit in one of the resident's bedrooms. The break glass unit for this door had been removed and on the day of inspection had not yet been replaced. The person in charge later informed the inspector that the resident had another key for this door which was kept on a hook in the bedroom. On review of the fire drill records it was noted that only two drills had occurred in the previous 12 months. This was not in keeping with the organisation's own policy. The detail in these records was very limited. This had been identified as an area for improvement in a six-monthly visit report completed by the provider. It was also identified that weekly fire checks had not been completed for a number of weeks.

Regulation 10: Communication

Each resident was not supported at all times to communicate in line with their needs. Not all staff who worked regularly with residents had received training in using the specific communication approaches assessed as required for residents.

Judgment: Not compliant

Regulation 11: Visits

Residents were facilitated to receive visitors in the centre in line with their wishes.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had access and control of their own belongings. There was adequate storage in each resident's bedroom for their clothes and other personal belongings. A system was in place to support the management of residents' finances.

Judgment: Compliant

Regulation 13: General welfare and development

Each resident attended a day service five days a week. Goals developed in the centre involved consultation with staff from these centres. Residents were familiar with their local and wider community and were supported to regularly access local services and amenities.

Judgment: Compliant

Regulation 17: Premises

The centre was clean and decorated in a homely manner. The kitchen area was well equipped and residents had access to laundry facilities. Areas where maintenance was required were identified in the house and back garden.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Residents were supported to buy, and participate in the preparation of, food in line with their wishes. There was evidence of choice at mealtimes.

Judgment: Compliant

Regulation 26: Risk management procedures

The system in place for the assessment, management and ongoing review of risk was ineffective.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire safety management systems required improvement. The containment measures installed in the centre were made ineffective due to the routine use of furniture and wedges to keep fire doors open. In addition, a door in the kitchen required review. A break glass unit had not been replaced in a timely manner. Fire drills had not been held at the intervals outlined in the organisation's policy.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

A comprehensive assessment of the health, personal and social care support needs had been completed for each resident living in the centre. However, elements of these assessments and their corresponding plans were not reviewed annually, as is required by the regulations. Residents' personal plans were not reviewed in line with the timeframes outlined by the organisation or the regulations. There was no evidence of residents' participation in the multidisciplinary review of their plans. The names of those responsible and the timescales for implementing recommendations generated at the multidisciplinary reviews were not outlined.

Judgment: Not compliant

Regulation 6: Health care

Appropriate healthcare was provided to each resident in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence that where required residents received input from behaviour support specialists and health professionals. Following review, the use of some restrictive practices in the centre had stopped. Training records were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 8: Protection

Management and staff working in the centre required additional training and support regarding the detection of abuse. As not all incidents of alleged or suspected abuse were recognised as such, the appropriate safeguarding procedures were not implemented.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for No.3 Stonecrop OSV-0005146

Inspection ID: MON-0023911

Date of inspection: 25/09/2019

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
The staff roster will continue to be prepared at least one month in advance.

Core staffing roster hours in the Centre are filled on a permanent basis.

The Person in Charge will ensure that there is 1:1 staffing to support one resident when in the care of the Centre in accordance with the safeguarding plan.

The Person in Charge has ensured that two regular relief staff are available to the Centre and other relief staff known to the residents are on the relief staff panel.

For scheduled staff absences, the core staff team and the regular relief staff will continue to be rostered.

Where there are unscheduled absences the PIC will ensure that relief staff known to the residents are rostered. The core staff team will continue to be flexible to ensure at least one regular staff member is rostered, where practicable.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider will ensure that the next Annual Review of the Centre, scheduled for November 2019, is carried out using the new Annual Review format. This includes a</td></tr>
</table>

specific section on consultation with residents and their representatives.

The Provider has ensured that core duties to be assigned to staff members are clearly set out, to ensure continuity, in the event of the absence of the Team Leader.

The Provider will ensure that the system of oversight arrangements are fully functional i.e.
· The daily report system as amended will prompt staff to ensure that all concerns are logged to the incident log and/or the complaints log, as appropriate. [24/10/2019]
· The PIC will continue to review the daily reports to ensure incidents are logged appropriately and that the log is reviewed at staff meetings. This log will inform the PIC of the incidents requiring notification to the Authority.
· The PIC and the staff team will review the incident log, the complaints log, the environmental issues including fire compliance issues as part of the review of Risk Register, which is now a standing Agenda item for the Team meetings. [03/12/2019]
· The Provider will ensure that all actions from the annual Review, the six monthly provider visits and from other inspections are logged in the Centre and monitored to ensure the actions are completed on a timely basis.
· The PIC and PPIM will review the Risk Register as part of their regular supervision meetings and will alert the Provider to high-risk issues in the Centre, including the use the new Provider Risk elevation procedure as necessary. [6/12/2019]

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 of the Centre has been updated to include the information required under Schedule 1 of the Regulations.

The minimum staffing levels based on full occupancy will be clarified on the Statement of Purpose.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Provider and Person in Charge has reviewed all daily report books since the date of the last inspection and tracked all concerns/incidents to the incident report book and to the notifications to the Authority.

All issues not notified will be notified retrospectively to the Authority. [2/12/2019]

The incidents will be reviewed by staff for learning with the PIC and the Designated person as appropriate at a focused risk management meeting. [03/12/2019]

The PIC will ensure the new daily report system will identify incidents requiring notifications in the future.

The Person in Charge will ensure that the PRN documentation [Protocol] is revised to provide more detail from the treating physician where the PRN is administered in relation to the management of a diagnosed underlying medical condition. [15/11/2019]
The Health Care management Plan in relation to an underlying mental health condition for one resident will be reviewed with psychology and enhanced if deemed necessary. [31/01/2020]

The Consultant has clarified with the dispensing pharmacist, the reason for the prescription of one medication for a resident. The Pharmacist has subsequently amended the Medication Administration Record to reflect this. [31/10/2019]

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Person in Charge and the Provider have reviewed all daily reports since the date of the last inspection and tracked concerns/complaints to the complaints log as appropriate. Any issues not already on the Complaints log will be entered. [15/11/2019]

The PIC will ensure that the Complaints log is fully completed to identify how complaints were closed off and whether the complainant was happy with the resolution.[15/11/2019]

The PIC will ensure that there is a system in place to ensure that any unresolved complaints will be entered to the risk register for management/elevation as necessary.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
All residents Communication Passports and personal profiles will be updated to reflect current communication supports required.

All regular relief staff will be trained on LAMH on 27 November 2019.

The PIC will ensure that the communication training identified for staff in the centre is included in the staff-training matrix and monitored on an ongoing basis.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The maintenance work is in the centre are scheduled for completion. The PIC has introduced a new maintenance log to ensure works requested are followed up on a timely basis.[7/11/2019]

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Provider together with the PIC and PPIM have reviewed all risks in the Centre's Risk Register and have identify other risks for consideration by the Staff Team and residents as appropriate.
The PIC will update the Risk Register with the staff team at a team meeting focused on Risk Management by 6/12/2019.

The PIC and the staff team will review the incident log, the complaints log, the environmental issues including fire compliance issues part of the review of Risk Register, which is standing Agenda item of the Team meetings.

The PIC and PPIM will review the Risk Register as part of their regular supervision meetings and use the Provider Risk elevation procedure as necessary.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Automatic fire door closures have been installed in the Centre.[18 October 2019]

A fire door in the Kitchen area has been inspected to ensure it fully closes.

A fire extinguisher bracket and break glass panel have been repaired. [2/10/2019]

The Safety Officer has confirmed that the emergency lighting is sufficient for fire evacuation purposes but will install an additional light in the hallway to benefit residents in the event of a power outage [20/12/2019]

A specific day in the week has been identified to carry out weekly fire checks. The responsibility for ensuring these checks are carried out is assigned to the post of responsibility on duty on the day. [26/09/2019]

The PIC will ensure that the required minimum 3 fire evacuations per annum are carried out and recorded on the Fire Register.

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 updated personal plans, including an updated assessment of need and personal goals are scheduled to be completed by 13 December 2019.

The Person in Charge will ensure the involvement of residents and their circle of supports in their plans is clearly documented.

The PIC and Team Leader will ensure adherence to the calendar for the quarterly review of plans.

The recommendations from the multidisciplinary input to the plans will be actioned at the subsequent quarter review of the plan.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Provider and Person in Charge has reviewed all incidents in the centre since the date of the last inspection. All safeguarding incidents will be reviewed with the Designated

and investigated further where necessary. [2/12/2019]

The Person in Charge has arranged for a team meeting focused on Risk Management [3/12/2019]. The Designated Person and the Complaints Officer will provide updated awareness training to the team at that meeting.

The Person in Charge will ensure that the system of monitoring, review and closure of safeguarding plans in the Centre is clarified.

The PIC will ensure that staff rosters, both projected and actual adhere to the additional staffing required for the duration of the safeguarding plan.

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(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	27/11/2019
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	29/09/2019
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Not Compliant	Orange	30/09/2019

	circumstances where staff are employed on a less than full-time basis.			
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	20/12/2019
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	07/11/2019
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	24/10/2019
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation	Not Compliant	Orange	30/11/2019

	with residents and their representatives.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	06/12/2019
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	18/10/2019
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	20/12/2019
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	02/10/2019
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,	Not Compliant	Orange	07/11/2019

	residents, are aware of the procedure to be followed in the case of fire.			
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	07/11/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	02/12/2019
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	02/12/2019
Regulation	The registered	Not Compliant		15/11/2019

34(2)(b)	provider shall ensure that all complaints are investigated promptly.		Orange	
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	15/11/2019
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	15/11/2019
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 need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	13/12/2019
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	Not Compliant	Orange	13/12/2019

	frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Not Compliant	Orange	13/12/2019
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	13/12/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any	Not Compliant	Orange	02/12/2019

	incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Not Compliant	Orange	03/12/2019