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:	St. Anne's Residential Services Group N
Name of provider:	Daughters of Charity Disability Support Services Company Limited by Guarantee
Address of centre:	Offaly
Type of inspection:	Short Notice Announced
Date of inspection:	24 September 2020
Centre ID:	OSV-0005163
Fieldwork ID:	MON-0030175

About the designated centre

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

St. Anne's residential service -Group N is a residential centre located in Co. Offaly. The centre currently affords a service to five adults, both male and female over the age of 18 years with an intellectual disability. The capacity of the centre is six residents. The service operates on a 24 hour 7 day a week basis ensuring residents are supported by care workers at all times. Supports are afforded in a person centred manner as reflected within individualised personal plans. Service users are supported to participate in a range of meaningful activities. The residence is a detached dormer house which promotes a safe homely environment decorated in tasteful manner.

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
Thursday 24 September 2020	09:00hrs to 15:00hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

On arrival to the centre the inspector had the opportunity to meet with one resident. They were having their breakfast at the dining room table interacting with staff. They told the inspector that they were heading off when their support staff came on duty for the day. The resident informed the inspector they were going to visit their family. They proudly spoke of following their healthy eating plan. This resident went about their day with their allocated support staff and had not returned when the inspection was complete.

Whilst in the dining room another resident joined the breakfast table upon getting up from bed. They interacted positively with staff and the inspector. They did not interact with their peer or greet them good morning. The resident smiled at staff when they gave them breakfast and laughed when they discussed their plan for the day. At this time another resident was having a lie in and a peer was being supported by staff.

One resident spent time in their bedroom listening in the rosary and was reported to enjoy spending time alone. The four residents remaining in the centre in the morning and completed in house activities with the support of day service team. In the evening whilst two went on a social outing one resident remained in house partaking in art. This resident chose not to interact with the inspector and this was respected.

The inspection occurred in accordance with current COVID 19 guidance. Interaction observed with residents and staff were professional and respectful in nature.

Capacity and capability

The inspector reviewed the capacity and capability of the service afforded within St. Anne's residential services Group N. A number of areas including governance and management and complaints required review to ensure a safe and effective service was in place. Improvements were required to ensure that when an identified concern was highlighted this was resolved in a prompt and effective manner.

The registered provider had appointed a suitably qualified and experienced person in charge to the designated centre. They had commenced their governance role six weeks previous to the inspection. The individual had taken this time to induct themselves to the needs of the service and the residents. They had ensured to communicate with the previous person in charge and person participating in management to promote consistency of support afforded to residents within the centre. This person had a reporting role to the clinical nurse manager assigned to

the centre.

The registered provider had ensured the appointment of a governance structure to the centre to preserve oversight within the centre. Lines of responsibility were clear. Communication within this structure nonetheless required improvement to ensure that all areas of support currently being addressed were knowledgeable to all. For example, ongoing communication with stakeholders and measures implemented to date to address an ongoing identified concern within the centre. Also the organisational work completed to date with regard to sourcing additional members of the multi-disciplinary team was not known to all individuals of the governance team on the day of inspection.

At organisational level the registered provider had ensured the enactment of regulatory required monitoring systems of the service provision. An annual review of service provision was completed in January 2020 by a delegated person. This review identified a number of concerns within the centre which reflected the service provided in 2019. The identified concerns encompassed for example a placement issue for one resident which was identified as causing distress to residents and overall resident compatibility issues.

When describing the impact of these issues, the providers annual review described the centre as "not a safe place to live in". Whilst this concern was identified and emphasised a robust action plan was not developed to promote resolution of the issue in a timely manner to promote the safety of all residents. In September 2020, a six monthly review of the service had been completed. This was completed by the person participating in management and was completed over a two day period. This did not address the identified concern of the most recent annual review, therefore a review of actions completed to date had not been completed to ensure a safe service was afforded to all.

At centre level a minimal amount of monitoring systems were completed. A number of monitoring and audit tools were available within the organisation to be implemented to oversee the safety and effectiveness of the service provided within Group N. However, many of the tools available had not been completed in over six months including infection control hygiene audit and the health and safety audit had last been completed in March 2019. This practice did not ensure that areas requiring improvements were identified and addressed in a prompt manner, for example review of restrictive practice within the centre and the monitoring of complaints.

The current staffing levels of the centre required review. The provider had identified that one individual benefited from one to one supports and that through this support a reduction in incidents may be observed. Current staffing levels within the centre did not correspond to this recommendation. Additional supports had been received through individualised staffing to promote community activation and individual supports. However, the centre was a lone working environment from 11pm to 8am. Through lone working staffing arrangements staff are unable to provide support to all resident should a behaviour of support occur. Four such recorded incidents of concern had occurred during this time since April 2020, which had resulted in

distress of residents. This had resulted in complaints from two residents and an increase in distress and anxiety for another on the subsequent day. No review of staffing occurred following same.

A number of staff training needs required refresher. A number of these training requirements had been postponed due to the ongoing COVID 19 pandemic. This had been identified by the provider as an area of risk and relevant risk assessments had been put in place. However, alternatives to training had not been identified in an interim basis including in house individual specific training. The person in charge had met with all staff members reporting for duty and discussed training needs as part of formal supervisory meetings.

On the day of inspection there was not clear evidence of adherence to organisational policy with regard to complaints. Communication with the complainant with regard to the complaint was not present, or the satisfaction of the complainant was not ascertained. The area surrounding the complaint remained active within the centre. Whilst some actions had been undertaken by the provider including a review of incidents this was not within complaints log or resident's personal plan. Records of complaints prior to July 2020 were not available for review within the centre as these had been reportedly destroyed during a behavioural incident.

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experienced person in charge to the designated centre. They had commenced their role six weeks previous to the inspection.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured 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. The provider had identified that a resident would benefit from one to one staffing, however current staffing levels within the centre did not correspond to this recommendation.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff were appropriately supervised. Due to the current COVID 19 pandemic some training had been postponed. Therefore not all staff had access to appropriate training, including refresher training, as part of a continuous professional development programme.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider had ensured the appointment of a clear governance structure within the centre. Lines of accountability were clear. Communication within this structure required improvement to ensure that all areas of support currently being addressed were knowledgeable to all. For example, ongoing communication with stakeholders and measures implemented to date to address an ongoing identified concern within the centre

Monitoring systems within the centre were not effective to identify and address concerns in a prompt effective manner. For example, the most recent six monthly unannounced visit to the centre in September 2020 did not address the identified concern of the most recent annual review, therefore a review of actions completed to date had not been completed to ensure a safe service was afforded to all.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. However, clarifications were required with respect to the description of rooms within the centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

On the day of inspection there was not clear evidence of adherence to organisational policy with regard to complaints. Communication with the complainant with regard to the complaint was not present, or the satisfaction of the

complainant was not ascertained.

Judgment: Not compliant

Quality and safety

As part of this inspection the quality and safety of the service was reviewed. It was identified by the inspector that a number of areas required review to ensure that the service provided was safe and effective. This incorporated positive behaviour support, protection of residents and the promotions of resident's rights. These will be discussed within the report. Areas of concern were identified to the registered provider on the day of inspection. The centre was not evidenced to be operated in manner which respected the rights of all residents. Residents did not for example have the freedom of their environment at all times. Interactions in the centre were at times completed in accordance with multi-disciplinary recommendations that were restrictive in nature.

A resident within the centre was identified by the provider in the annual review of January 2020 as requiring an individualised service. This was an ongoing concern which had an impact on all residents within the centre. The resident had also expressed their choice of living arrangements to be different. Whilst a number of actions had been completed to date to address this wish, limited advances had been made. For example, alternative accommodation and funding had yet to be identified. An independent advocate had not been sourced to assist the resident as required. It was unclear if or when an application regarding same had been submitted to the external funding body. The registered provider had received some additional funding to provide additional staffing hours for this individual to promote daily activities and to promote community integration in the evening. This included supported employment a number of evenings a week.

The person in charge had not ensured that staff were provided with sufficient knowledge skills and experience to support all residents through behaviours of concern. An inconsistent approach to supports were in place. The inspector reviewed a number of behaviour supports plan in the day of inspection and found a range of templates both for documenting incidents, mood and behaviours but also in the method of providing guidance for staff. One plan was extremely comprehensive with a vast range of reactive strategies. Whilst another resident's plan had not been fully completed. This plan not include for example, the early signs of distress or anxiety. A resident had displayed an increase in behaviours from February 2020, this was discussed as part of their annual review also in February 2020. However, they continued to await the completion of a behaviour support plan. Staff were not afforded with guidance on how to support the resident at times of concern or how to document incident to allow for review or trending of incidents.

An inconsistent approach to recording of incidents and behaviours of concern was

also evident. Not all incidents were recorded so trending and review of behaviours was not effective or reflective of the current situation. Where incidents were recorded sufficient information was not present for example when recording antecedents the people present was not noted or what was occurring in the immediate environment. It was not noted what aspects of the behaviour support plan were effective, if utilised, or of not was they were deemed to be ineffective. Information provided within the documentation was limited with a number of templates being utilised to record the same subject. This required review.

Over recent months a reduction in the use of restrictive practices had been completed for one resident in relation to the use of an alarm on their armchair due to an assessed falls risk. This was a positive occurrence. A log of all recognised environmental restrictions was completed. The registered provider had not identified however a number of practices which were restrictive in nature within the centre. Guidance for staff set out within a safeguarding plan and behaviour support guidance was restraining in for example, allowing residents free access to their environment. Residents were removed from an area should an incident occur and one resident would not spend time in an area of their home when a peer was present. The registered provider had not recognised this as restrictive actions which had an impact on the individuals in the centre.

The provider had self-identified that the placement of one resident "is of concern to peers". One resident requested a lock on their bedroom door to maintain their privacy and to prevent a peer causing damage to their property during times of concern. Two residents have submitted complaints with regard to the distress behaviours of concern have caused them. Whilst it is acknowledged that the provider is actively sourcing alternative accommodation for an individual measures in place to safeguard all residents from all forms of abuse were not effectively monitored. At the time of inspection only one safeguarding plan was in place. This did not reflect the need of the individual but of the person alleged to have caused concern. Whilst the provider stated that this was on going concern, safeguarding plans were not in place for all to ensure a consistent approach to support. The long term impact of the compatibility issue within the centre was not recognised.

The registered provider had not ensured 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. Whilst a risk register was in place with regard to the designated centre this required review. A number of current control measures set out were not in place for example staff training. As part of a recent review a number of risk had been amended to reflect an identified risk for one resident and not the centre as a whole. This included the lone worker policy. In conjunction to this a number of risk had not been identified including safeguarding and the display of threatening behaviours.

Regulation 13: General welfare and development

The registered provider had ensured the provision of opportunities to participate in activities in accordance with their interests, capacities and developmental needs including employment for one resident.

Judgment: Compliant

Regulation 25: Temporary absence, transition and discharge of residents

The person in charge had not ensured a resident was receiving appropriate support as they transition between residential services or leave residential services through the provision of information on the services and supports available.

The resident had also expressed their choice of living arrangements to be different.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider had not ensured 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. For example, a number of current control measures set out within the risk register were not in place for example staff training in the area of behaviours of concern.. As part of a recent review a number of risks had been amended to reflect an identified risk for one resident and not the centre as a whole e,g lone worker.

Judgment: Not compliant

Regulation 27: Protection against infection

The registered provider had ensured that residents and staff were protected from infection. During the current pandemic individuals were protected by adopting procedures consistent with the national guidance.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had not ensured 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. Guidance and recording of incidents was done so in an inconsistent manner.

Also, the registered provider had not ensured where restrictive procedures are used, such procedures are recognised as such and applied in accordance with national policy and evidence based practice.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had not ensured effective measures were implemented to protect all residents from all forms of abuse. Guidance with respect to safeguarding measures were not consistently in place and measures were not specific to the individual needs of the residents.

Judgment: Not compliant

Regulation 9: Residents' rights

The centre was not evidenced to be operated in manner which respected the rights of all residents. Residents did not for example have the freedom of their environment at all times. and freedom of interactions with staff.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 25: Temporary absence, transition and discharge of residents	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for St. Anne's Residential Services Group N OSV-0005163

Inspection ID: MON-0030175

Date of inspection: 24/09/2020

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Registered Provider and Person in charge have reviewed the staffing and in view of the predominant need for extra supports has reviewed the roster. This review has put in place the extra supports needed in the evening where possible over 7 days of the week. On two evenings the resident is supported by day service staff to attend supported outreach employment projects. On 5 evenings per week there is a residential staff to support in the evening to enable residents in accessing community, go out for a drive or an activity of choice. The PIC and staff team have developed a planner to promote a fair and equitable service for all. The registered provider and Person in Charge reviewed the correlation between night disturbances and residents' concerns. Following this review the need for an enhanced level of staffing at night has been proposed and a business case to the HSE has been submitted to fund this increase in staffing. The Registered provider having identified that this resident would benefit from one to one staffing and has written again to the HSE to seek funding for same in the current centre.This placement matter has been escalated within the HSE by the CEO and ACEO.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The registered provider and Person in Charge have reviewed the training records in the centre with the Training coordinator and the two staff outstanding re medication management were trained 14/10/2010. Refresher training re hand hygiene and Children's first was completed on line. The Service completed an assessment on safe	

practices in training and face to face training is resuming as soon as national covid-19 restrictions permit same. The PIC will ensure that staff are booked into receive their refresher training in mandatory courses and utilise educational on line resources to address deficits where effective. All outstanding training needs will be ascertained by the PIC and staff will be enrolled in upcoming training sessions to address same. The provider has sought bespoke training for the area in relation to risk management and processing complaints which will be facilitated through the Quality and Risk department. The MDT- Social work department and Speech and language department have put in place online training in relation to recognizing distress in non-verbal residents. This training was provided 23/10/2020

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The registered provider will ensure an effective governance and management structure is in place to support the centre. The registered provider has reviewed the existing supports to the center and identified the following measures to be actioned to ensure a high standard of governance and management;
The registered provider will ensure the new PIC is under the guidance of the PPIM with regular supervision meetings in place.
The registered provider will ensure key stakeholders and the PIC are kept up to date on issues pertaining to the centre through centre governance / house meetings with PPIM and PIC.
The registered provider has updated the supervision document to reflect progress of the centres core issues to ensure there is ongoing dialogue and information sharing across the management structures.
The registered provider will ensure a system is in place with the PIC and PPIM to monitor progress on action plans. The person in charge and the person participating in management of the designate center since inspection are reviewing all audits and actions from same. Review dates will be put in place identifying responsible staff member/team members to action same, in set timeframes. The registered provider will ensure the person in charge and the person participating in management will thereafter review these quarterly, or more frequent where required
The registered provider will ensure the PIC and PPIM review previous unannounced provider audits and develop action plans on the 6 monthly provider audits. These will be reviewed and updated prior to the next unannounced provider audit.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The person in charge has updated the statement of purpose and submitted same to HIQA reflecting the points raised at inspection.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Registered provider will ensure the relevant documentation is recorded and maintained and up to date with respect to complaints as per organisational policy and that the complainant is informed promptly of the outcome of their complaint, in line with organisational policy.

The registered provider will ensure training is provided to the staff team on the complaints procedure to ensure it is compliant with organisational policy and that all complaints are actively managed and escalated as required, and that the complainant is kept informed throughout the process.
Since the inspection the PIC has ensured each personal plan has been updated with specific direction for staff and residents re follow up on /complaints.

Regulation 25: Temporary absence, transition and discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
The registered provider has completed an assessment of need and a business case for an individualised service for one resident and submitted same to the HSE for funding approval. The support needs for this resident and progress on this business case will be reviewed monthly at the Service Admission Discharge Transfer committee. The person in charge will ensure that the resident and her ward of court committee are kept informed of these developments. Once this plan has been approved for funding the PIC will develop a transition plan with the resident and her ward of court committee.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Registered provider will enlist the Quality and Risk officer to review the risk management procedures in the centre and support the staff team and Person in Charge with regard to review of current risk management systems, development of robust risk assessments, control measures, risk rating to ensure all risks are identified, actively managed and escalated as required.
The PIC will complete a review of the training needs analysis for this centre and ensure staff have access to on line training and supports. As assessment on safe practices in training has been completed and face to face training is resuming. The PIC will ensure that staff are booked into receive their refresher training in mandatory courses as well as risk management.
The current risk register will be updated to highlight risks related to Covid 19 and arrangements in place to address same.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The registered provider along with the PIC and Psychology Department commenced a review of the behaviour support plan for one individual. Dates for review 13/10/2020 and a further meeting 21/10/2020.

The registered provider and The Psychology Department have agreed to prioritise this centre with a view to reviewing all residents behavior support plans and or guidance documents to improve the overall consistency of documentation across this centre and develop an improved overall standard at the end of the process.

The Person in Charge will complete a review of behavioural support plans in this centre with the psychology department and staff team to ensure staff have up to date knowledge and skills appropriate to their role to respond to behaviours that challenge and support residents to manage their behaviour. The Use of templates and monitoring sheets are being reviewed by Psychology with the staff team with the aim of utilising the information documented to analyse trends and commonalities. The PIC and PPIM will monitor the recording and implementation of the BSP in this area to ensure consistency.

The PIC will complete a review of the training needs analysis for this centre and ensure staff have access to on line training and supports. As assessment on safe practices in

training has been completed and face to face training is resuming. The PIC will ensure that staff are booked into receive their refresher training in mandatory courses including management of challenging behaviour.

The registered provider will ensure with the PIC , Quality and Risk officer and MDT review the behaviour support plans for this centre with a focus on restrictive practices to ensure all restrictions are recorded, applied and documented in line with organizational policy

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Since the inspection the registered provider held a safeguarding meeting with the PIC and MDT and all residents now have a safeguarding plan in place. The PIC has reviewed processes in the house and put a number of positive steps in place; these include one to one staffing in the evening for one resident and utilizing same to promote evening activities for the residents and outreach employment programme for one individual, nightly de-brief for the residents with staff on duty to support the individuals to express their emotions in a structured manner.
Following a meeting with the registered provider a resident was offered a journal to document their feelings with support from staff and reassurance that the service was doing all that was possible to support re their complaint.

The safeguarding plans have been updated to reflect the needs of the individual who owns the plan and outlines how these needs are to be met and supported. A process for documenting the impacts of complaints and incidents on the individual residents has been incorporated into each personal plan. Training on recognizing discomfort and concerns in non-verbal residents has been put in place via MDT team.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The registered provider will ensure the PIC, Quality and Risk officer and MDT review the behaviour support plans for this centre with a focus on restrictive practices to ensure all restrictions are recorded, applied and documented in line with organisational policy. Two meetings regarding behaviour support plans have been completed with stakeholders to review one plan with a view to eliminate the environmental restriction involved in aspects of this plan. This is now complete.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/11/2020
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.	Substantially Compliant	Yellow	31/01/2021
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management	Not Compliant	Orange	30/11/2020

	structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	31/12/2020
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/03/2021

Regulation 25(3)(a)	The person in charge shall ensure that residents receive support as they transition between residential services or leave residential services through:the provision of information on the services and supports available.	Substantially Compliant	Yellow	31/10/2021
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	31/12/2020
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	31/10/2020
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	30/11/2020
Regulation 34(2)(e)	The registered provider shall ensure that any	Not Compliant	Orange	30/11/2020

	measures required for improvement in response to a complaint are put in place.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	30/11/2020
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.	Not Compliant	Orange	31/03/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/03/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Substantially Compliant	Yellow	31/01/2021

	procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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.	Not Compliant	Orange	31/01/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal	Not Compliant	Orange	31/12/2020

	information.			