Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

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

Name of designated centre:	Desmond Community Residential Houses
Name of provider:	Brothers of Charity Services Ireland
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	14 March 2019
Centre ID:	OSV-0005179
Fieldwork ID:	MON-0024820

About the designated centre

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

This designated centre consists of two houses in separate locations; one is a short commute from the town but both are in close proximity to the range of amenities offered by the busy town.The provider's day service that some residents attend is also easily accessed from the houses. Transport is provided.

A maximum of nine residents can be accommodated and generally eight residents live in the centre; one resident attends on an irregular basis. Four residents live in one house, five in the other. Each resident has their own bedroom and share recreational, dining and bathroom facilities.
The model of care is social; the staff team is comprised of a team of social care workers led by the person in charge. The provider states that the centre is not suitable for residents with high physical or medical needs. The provider aims to provide each resident with a safe but homely environment and support that promotes independence and quality care based on individual needs, requirements and wishes.

The following information outlines some additional data on this centre.

Current registration end date:	31/07/2021
Number of residents on the date of inspection:	8

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
14 March 2019	09:30hrs to 18:30hrs	Mary Moore	Lead

Views of people who use the service

The inspector met with seven of the eight residents living in the centre. Some residents engaged on a one to one with the inspector; others engaged as they went about their daily routines.

Residents presented as well and confident in their environment and free to express their views and opinions in the presence of staff. Residents expressed an interest in the inspector and what it was that the inspector did; some recalled the inspector from previous inspections of this centre.

Residents spoke of what it was that they enjoyed in life and confirmed that they had attended meetings about their personal objectives and what these were. Residents spoke of family, how important this was to them, the impact of recent loss and the support that they received. Residents were familiar with their key-worker and link-worker and clearly had a good relationship with them.

One resident also spoke about what it was that they did not like about living in the centre. This feedback is reflected in the findings presented in the quality and safety section of this report.

Capacity and capability

There was scope for improvement in the governance of this centre to ensure that notwithstanding the challenges posed, the management of these challenges ensured that residents were in receipt of the best possible service, a service that was appropriate to their needs and of the best possible quality and safety.

There were many indicators of good governance. For example while there had been changes to the management structure these changes had provided for stability and continuity for residents and continuity of knowledge of their needs. There was clarity on individual roles, responsibilities and reporting relationships. The person in charge was based in the day service and worked closely and collaboratively with the other person in charge based in this geographical location. They worked opposite each other so as to maintain a management presence and oversight. The area manager was also based locally and had established experience and knowledge of the centre and residents. Therefore there was daily contact and support between management in addition to the formal reviews that took place weekly.

The provider had systems for self-identifying challenges to the quality and safety of the service and the action necessary in response; these systems included risk management processes, review of incidents and multi-disciplinary reviews (MDT) of the supports provided to residents. However, deficits in these systems impacted on their overall effectiveness (discussed in the next section of this report). In addition the provider was also completing the unannounced reviews required by the regulations. The inspector reviewed the report from the most recent review (October 2018) and saw that the review was thorough, had been completed when residents and staff were in the centre and so maximised the opportunity to observe practice and obtain feedback from staff and residents. The review highlighted the issues that were impacting on the quality and safety of the service such as the challenge and risk posed by peer to peer incidents. However, action taken in response to the review was not sufficiently robust to effect change or improvement. This is explored further in the next section of this report; this section concerns itself with the requirement for more robust and effective governance.

Overall the inspector found that the provider had ensured that staffing levels and arrangements were adequate. Ordinarily there was one staff on duty in each house and the night-time arrangement was a sleepover staff. Additional staff resources had been made available in response to specific needs to provide individualised support; this meant that there was an additional staff present in each house for approximately sixteen hours in one house and thirty seven hours in the other.

There was a planned staff rota; a team of regular staff and a small core number of relief staff worked in the centre. The inspector was advised that staff were supported in their work by regular formal and informal meetings and were free to raise any concerns that they had about the service.

The provider demonstrated that they could listen to and act on feedback about the service. The inspector saw that staff did raise concerns at staff meetings and staff also supported residents to complain if they wished to about the service they received. Based on the findings of the providers last internal review and these inspection findings there was evidence of improved complaints management. Proposed solutions to complaints are however referenced again the next section of this report.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. Though relatively new to the centre and to the process of regulation the person in charge facilitated the inspection with ease and had good knowledge of the residents and their needs and of the general operation and administration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels were adequate and reflected the assessed needs of the residents. The inspector found that the provider assessed the adequacy of staffing and additional supports had been provided.

Judgment: Compliant

Regulation 21: Records

The inspector found that any of the requested records as listed in part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities Regulations 2013 were in place. In general the records were well maintained and the required information was easily extracted by the inspector from the records.

Judgment: Compliant

Regulation 23: Governance and management

While there were many indicators of good governance a review of governance and its effectiveness was required. Findings indicated that while action was taken where needed, the improvement necessary was not always achieved and therefore the quality and safety of the service experienced by residents was not consistent and was negatively impacted.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The complaints log demonstrated that residents knew how to complain and did complain; staff supported residents to record and progress their complaints. There was evidence of improved complaints management the provider having itself identified deficits in this process.

Judgment: Compliant

Quality and safety

With due regard for each residents disability and needs there were times when these needs impacted on residents themselves, on peers and on staff. The provider did seek to support each resident on an individualised basis including in times of escalated need. However, the needs of residents and the failings identified in the provider's measures to support them resulted in a service that was not always safe or of the best possible quality.

The support provided to each resident was informed by the assessment of their needs; a plan of support was then devised based on the assessment findings. There was evidence that residents and their representatives were consulted with in relation to the support that was provided. The effectiveness of the plan was also subject to review by the multi-disciplinary team (MDT). However, records seen indicated that the plan was not always updated in a timely manner to reflect changes in needs and circumstances as they occurred. Where requests had been made for a specific clinical review there was a lack of timely follow-up. In addition the composition of the MDT review did not always reflect the needs and supports to be discussed and the decisions to be made; for example in relation to medicines management. Collectively these deficits did not provide assurance that the plan of support was what guided support on a daily basis or that the system of review was sufficiently robust to establish the appropriateness and effectiveness of the support provided.

One element of the personal planning process that had not been reviewed as needed was a plan for the prevention and support of behaviours of concern and risk; the behaviour support plan in question was dated January 2017. Given resident needs there was a requirement for this plan to be current and to guide and inform practice on a daily basis. The inspector saw that this lack of review was identified by the providers own internal audit of October 2018 and had also been requested by a clinician in February 2019. The lack of appropriate clinical review did not provide assurance in relation to recent decisions and changes made as to how the resident should be supported; for example revised instructions on the administration of PRN (as required) medicines in response to incidents of behaviour and interim guidelines that had been issued to staff in relation to the use of a particular reactive strategy. Also records maintained of the administration of these medicines did not provide the required assurance that they were a necessary intervention at that point in time or administered only when therapeutic interventions had failed.

The provider had other systems that informed the support provided to residents in relation to both behaviour that challenged and their general support needs; these systems included risk management processes and the recording and management of incidents and accidents; the frequency of the latter were used the inform the calculation of risk. However, the inspector noted that there was inconsistency between risk assessments, incident records, clinical records and daily narrative notes as to the frequency of incidents, for example the regularity of disturbance of residents at night-time. This inconsistency impacted on the accurate calculation of the number and frequency of incidents and on the estimation of risk and impact particularly in relation to behaviours. Risk identification and management did not based on these inspection findings prevent harm from occurring.

Ultimately and particularly in one of the two houses that comprise this designated centre resident's needs were not compatible and the suitability of residents living together required further review and action. Residents each individually presented with behaviours that were unique to them, their disability and individual wishes; it was reasonable to assume that in any context behaviours would present and would require support. However, the interaction in this particular house meant that when behaviours presented they impacted on the other residents and were also at times specifically directed at a fellow resident. The consequence was harm and upset on an individualised basis or more generalised disruption to the house and residents that resulted in poor sleep patterns, disrupted sleep and early morning waking and general poor presentation and heightened anxiety the following day. Missing from the provider's management of this house and the support provided to each resident was the cyclical nature of the behaviours; that is how the behaviour of one resident was the trigger for the behaviour of another. As a result this house could not be described as consistently safe for any of the three residents living there.

Therefore notwithstanding the uniqueness of each resident and their needs, residents individually and collectively were not always adequately protected from harm by a peer. While there was no immediate risk to residents at the time of inspection and while the provider had some effective systems in place, residents lived in an environment and in circumstances that made all residents vulnerable to both causing harm and experiencing harm. This harm took many forms and included physical harm and fear of physical harm; lack of control over their private space and personal possessions, disruption to sleep and the risk that this presented to physical and psychological well-being and further behaviours that challenged. Peer impact was referenced in clinical records seen where residents articulated anxiety in relation to their peers and clinicians highlighted the impact of environmental factors as contributing factors to general presentation and behaviours. One resident spoken with told the inspector that they did not like living in the house; the reasons cited were as evidenced in the records seen.

Based on records seen, it was evident that a review of safeguarding processes was required. Discussion, agreement and clarity was required on the recognition, reporting and management of peer on peer incidents including incidents for which there were already safeguarding plans in place.

Overall it was evident that the individuality of each resident was recognised and

respected. However and notwithstanding the finite nature of resources there was a requirement to review the general operation and provision of the service to ensure that the person, their choices, preferences and rights were always at the centre of exchanges and decisions rather that the person fitting into what the service could offer. This was relevant in the context of the unsuitability of residents needs as discussed above but also in relation to more routine, day to day matters. A resident had awoken feeling unwell and had expressed a desire to remain in bed rather than attend the day service; this was not facilitated. Based on records seen this was a reasonable request of the resident; the resident did not however have the freedom to exercise choice and control over their routine that day. The resident had been supported to make a complaint about this but again the solution proposed did not put the person, their choices and rights at the centre of the proposed solution should a similar situation arise.

The inspector saw that residents, including any who had experienced prolonged periods of poor health looked well and were currently enjoying good health. Staff monitored resident well-being and sought timely referral to their General Practitioner (GP). There was documentary evidence that residents were offered seasonal influenza vaccination and access to national screening programmes. Residents had access to other healthcare services and professionals such as physiotherapy, neurology, occupational therapy, chiropody and dental care.

Previous inspections and internal reviews on behalf of the provider had identified that the provider needed to develop and improve its fire safety management systems. The provider had submitted a plan to HIQA for these works. The inspector saw that the provider had completed the first phase of these works and had installed emergency lighting and fire detection systems. However, infrastructural works to contain fire and smoke and protect escape routes were still required in each house.

The inspector found no deficits in the provider's internal fire safety procedures. Staff had completed fire safety training, the majority in 2018. Fire safety equipment was inspected and tested at the required intervals and staff completed daily visual inspections and weekly tests. Staff convened regular simulated evacuation drills with residents; records of these indicated that all residents participated and good evacuation times were achieved.

Regulation 26: Risk management procedures

There was inconsistency noted in the way risk was managed which impacted on the accurate calculation of the number and frequency of incidents and on the estimation of risk and impact particularly in relation to behaviours. Risk identification and management did not, based on these inspection findings, prevent harm from occurring.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Infrastructural works to contain fire and smoke and protect escape routes were still required in each house.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The plan of support was not always updated in a timely manner to reflect changes in needs and circumstances as they occurred.

The system of review was not sufficiently robust to establish the appropriateness and effectiveness of the support provided.

Resident's needs were not compatible and the suitability of residents living together required further review and action.

Judgment: Substantially compliant

Regulation 6: Health care

Staff assessed, planned for and monitored residents healthcare needs. The provider had responsive arrangements to ensure that each resident has access to the range of healthcare services that they required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The plan for the prevention and support of behaviours of concern and risk had not been reviewed as needed.

The lack of appropriate clinical review did not provide assurance in relation to recent

decisions and changes made as to how the resident should be supported.

Records maintained of the administration of PRN medicines did not provide the required assurance that they were a necessary intervention at that point in time or administered only when therapeutic interventions had failed.

Judgment: Not compliant

Regulation 8: Protection

Residents individually and collectively were not always adequately protected from harm by a peer. Residents lived in an environment and in circumstances that made all residents vulnerable to both causing harm and experiencing harm.

Based on records seen, it was evident that a review of safeguarding processes was required.

Judgment: Not compliant

Regulation 9: Residents' rights

Notwithstanding the finite nature of resources there was a requirement to review the general operation and provision of the service to ensure that the person, their choices, preferences and rights were always at the centre of exchanges and decisions rather that the person fitting into what the service could offer.

Judgment: Substantially 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
Views of people who use the service	
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Desmond Community Residential Houses OSV-0005179

Inspection ID: MON-0024820

Date of inspection: 14/03/2019

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
With regards to 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.

• PIC will complete monthly review of incidents on the AIRS system.

• Discussion and learning from the review of incidents will be discussed and documented by PIC with staff at Monthly Team Meetings.

• MDT reviews for persons supported by the service will take place with input being sought directly from Psychiatry if required or via the MDT professionals.

• All plans developed to support an individual, including Healthcare, Behaviour and Safeguarding Plans will be reviewed in a timely manner by the relevant professional in consultation with the PIC.

• Issues highlighted in Internal Unannounced Inspections will be advanced by PIC in a timely manner after the report has been received.

• Local management in conjunction with the Head of Community Services prepared a revised mix of resident draft list in the context of 2 new houses planned to open. This draft will be reviewed by the MDT on May 14th 2019.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
With regards to Regulation 26 (1)(d) - The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

• PIC will review incident recording system (AIRS) on a monthly basis.

• PIC will ensure that at team meetings, incidents that have occurred will be discussed along with the key learning from serious or adverse events.

• PIC will attend next risk management clinic scheduled for May 21st 2019 to review high-level risks in conjunction with the Director of Services, Head of Quality and Risk and Head of Community Services.

• Key learning will be utilized in the development of risks and personal plans.

• Risks will reflect the impact that an incident/event may have on the psychological wellbeing of a resident.

• PIC will ensure that risk ratings will be updated according to the impact and frequency of incidents / events.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
With regards to Regulation 28(1) - The registered Provider will ensure that effective fire safety management systems are in place:

• In addressing Condition 8, Phase 1 of fire safety upgrades was completed (Emergency Lighting and Automated Fire Detection Systems installed in both houses).

• In both houses, there is a Fire register. A number of daily, weekly, monthly, quarterly and annual inspections/tests of the Fire System are carried out by staff and specialist in the area of fire safety systems.

• Person's supported by the service are aware of what to do in relation to Fire Safety and take part in regular fire drills in the Designated Centre.

With regards to Regulation 28(3) - The Registered Provider shall make adequate arrangements for: (c) detecting, containing and extinguishing fires:

This designated centre is comprised of two house:

House 1:
• L1 Automated Fire Detection System and Emergency Lighting has been installed in both houses and certified by a Fire safety Engineer.

• A comprehensive programme of fire safety measures are in place and these will continue to be implemented as mitigations to the fire safety risk.

• Alternative property has been sourced with support from Limerick City and Council.

• Design and Tender process completed.

• Works to be completed by end of year 2019.

• New House will be registered with HIQA and will replace House 1.

• Application to vary will be completed once registration on the alternative property is complete.

House 2:
• L1 Automated Fire Detection and Emergency Lighting has been installed and certified by a Fire Safety Engineer.

• The house will be included in HSE process re Fire Safety as outlined in the plan submitted to HIQA on 12th April 2019.

• An "Application for the variation or removal of a condition" was submitted to HIQA in February 2019 with respect to Condition 8 and requested in the absence of containment, to operate in the current location until 31st March 2020.

• A comprehensive programme of fire safety measures are in place and these will continue to be implemented as mitigations to the fire safety risk

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
With regards to Regulation 5(02) - The registered provider shall ensure, insofar as is

reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).

• PIC to ensure that the Personal Plan is developed to meet the needs of each person through the referral and support of members of the MDT.

• Reviews of all plans in place for a person supported by the service, such as Behaviour Support Plans will be reviewed as required by the Behaviour Support Staff in consultation with the PIC and Staff.

• Reviews of plans will seek to determine if the interventions/strategies in place are appropriate and effective.

• Local management in conjunction with the Head of Community Services prepared a revised mix of resident draft list in the context of 2 new houses planned to open. This draft will be reviewed by the MDT on May 14th 2019.

With regards to Regulation 5(06)(d) - The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.

• Personal Plan will be reviewed, by the PIC, as required.

• PIC will ensure that elements of the Personal Plan that require MDT members to review and update that plan will be completed as it is required.

• Personal Plans will be updated if there is a changes in circumstances or for developments that occur. The Personal Plan will be a "live" document reflecting the individuals' current status and presentation.

With regards to Regulation 5(08) - The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).

• The PIC will ensure that the Personal Plan will be a "live" document reflecting the individuals' current status and presentation. Any changes that occur for the person will be updated in the Personal Plan.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: With regards to Regulation 7 (3) - The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process. The Registered Provider will ensure that: • Easy Read material is developed to communicate an understanding of any intervention proposed. • Person supported by the service is informed about therapeutic interventions and the consent of the person is sought with respect to any proposed intervention. • Reviews of all plans in place for a person supported by the service, such as Behaviour Support Plans will be reviewed as required by the Behaviour Support Staff in consultation with the PIC and Staff. • Any updates / modifications to therapeutic interventions will be facilitated through the MDT professionals and discussion with Psychiatry with respect to the use of PRN medication. • PRN Protocol will be reviewed to indicate the use of all other interventions are used to support the individual prior to use of PRN. With regards to Regulation 7 (5)(b) - The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used. • The PIC will ensure that PRN protocols are updated as required.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: With regards to Regulation 8(2) - The registered provider shall protect residents from all forms of abuse. • Local management in conjunction with the Head of Community Services prepared a revised mix of resident draft list in the context of 2 new houses planned to open. This draft will be reviewed by the MDT on May 14th 2019. • The PIC will work with staff in following the Brothers of Charity Safeguarding Policy,	

clarifying the recognition, reporting and management of incidents between peers.

• At staff meetings, the PIC will work with staff in following the process of contacting the Designated Officer and discussing with the Designated Officer events/incidents that meet the threshold of abuse.

• The impact of all incidents / events will be utilized to inform the management of risks, their rating, and the appropriate controls to protect each individual.

With regards to Regulation 8(3) - The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

• The PIC will ensure that all incident, allegation or suspicion of abuse are reported to the Designated Officer. The PIC will ensure that staff are aware of reporting arrangements in the PIC's absence.

• Safeguarding Plans will be put in place and any actions identified in the plans will be implemented to protect individuals from abuse.

• Safeguarding Plans will be reviewed in a timely manner to check that the actions in the plan are appropriate and capable of protecting the individual.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
With regards to Regulation 9 (2) (b) - The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.

• PIC to ensure that at staff meetings, review and promote the person centredness of service provision to ensure that the person, their choices, preferences and rights are at the centre of service provision.

• Designated Provider to ensure that we put the person, their choices and rights at the centre of proposed solutions whilst utilising the resources of the service.

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 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.	Substantially Compliant	Yellow	30/06/2019
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/06/2019

Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/03/2020
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/08/2019
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/08/2019
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Substantially Compliant	Yellow	30/08/2019
Regulation 07(3)	The registered	Not Compliant		30/09/2019

	provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.		Orange	
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/09/2019
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/07/2019
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	30/07/2019
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in	Substantially Compliant	Yellow	30/07/2019

	accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.			