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:	Broadleaf Manor
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	14 November 2023
Centre ID:	OSV-0003397
Fieldwork ID:	MON-0032477

About the designated centre

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

Broadleaf Manor is a large detached residence located in a rural setting close to a small village in Co. Kildare. The property is subdivided into six separate living areas, four of which are self-contained apartments. The property is homely, well maintained, spacious and clean. The centre provides care and support to both male and female adults, all of whom require support around their mental health needs. The provider has supplied a number of vehicles in order to transport residents to their day services and to access local amenities. Residents are support by the staff team 24 hours a day seven days a week in line with their assessed needs. The staff team comprises of a person in charge, team leaders, deputy team leaders, social care workers and assistant social care workers. Residents have access to a range of allied health professionals in line with their assessed needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 (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
Tuesday 14 November 2023	10:00hrs to 18:40hrs	Sarah Cronin	Lead
Tuesday 14 November 2023	10:00hrs to 18:40hrs	Marie Byrne	Support

What residents told us and what inspectors observed

This was an announced inspection which took place to inform a decision about the renewal of registration of the designated centre. From what residents told us and what the inspectors of social services observed, it was clear that residents living in this centre were enjoying a good quality of life and that they were supported to pursue activities of their choice in the community. Inspectors found that significant improvements had been made in the centre since the last inspection and this was evidenced by an increase in the levels of compliance found with the regulations.

The centre is a large two-storey house in a rural setting outside a small town in County Kildare. The ground floor of the house comprises a kitchen and dining area, a sitting room, a wet room, a monitoring room, a utility room and three supported living environments where residents had their own bathroom, bedroom and living area. There were large self-contained gardens to the back of the property. The house had a large garage to the rear which acted as a games room. There were games consoles, a punch bag and a pool table. The person in charge reported that residents often used this space for their weekly forums. Upstairs there was another supported living environment and three resident bedrooms, all of which were en-suite. There were two staff sleepover rooms and an office. Since the last inspection, the provider had done some works on the property which included painting, replacing of some flooring, furniture and renovation of the kitchen and a bathroom. This meant that the centre had a more homely atmosphere.

Residents in the centre used speech, body language, facial expression and behaviour to communicate. Residents were reported to benefit from the use of visual supports such as the written word, having information in an easy to read format and use of visual schedules and planners.

On arrival to the centre, one of the residents was seated in the hallway speaking with staff. They greeted inspectors and the person in charge with a smile. They showed inspectors their living area and some of the paintings they had done. Their living area was decorated with their artwork and family photographs. The resident had a collection of speakers and enjoyed listening to music. They were going through their plans for the day with their staff and later went out. The resident told inspectors that if they had any concerns that they spoke with the person in charge and that they'd "sort it out" for them. The second resident who inspectors met showed the inspectors their curriculum vitae and spoke about wanting to get a job. They had done training courses and work experience and were engaged with the provider's outreach department to source suitable employment for them in line with their interests. They reported that they wished to move on to a less restrictive environment. This was being explored with other service providers on the day of the inspection. The third resident was seated in their apartment and was watching television with two staff members. They had recently gotten their room painted and had requested a 'glitter wall' which had been done. This resident lived in a highly restricted environment due to their complex needs. They appeared comfortable in

the company of staff. The fourth resident was in their apartment and chose not to engage with inspectors. Due to their presentation the night prior to the inspection taking place, closed circuit television (CCTV) had been in use at the entrance to their apartment due to assessed risk. Inspectors observed the resident coming to the phone at the entrance to their apartment and requesting for the staff to enter their living space. The fifth resident was seated out in the garden and told inspectors that they were going to a park with a member of staff later. The resident had been supported to have a contract and was proud to say that they were now 64 days without any incidents. Since the last inspection, the resident had their own portion of the garden divided so that they were able to enjoy their own space. One inspector had the opportunity to meet one of the residents later in the afternoon. The resident told the inspector that they enjoyed going out to get coffee in different coffee shops around the country. They planned on going out with staff in the afternoon for a coffee and to a local farm food shop.

Residents in the centre had access to a games room out the back garden. This was a converted garage and contained a pool table, a punch bag, a Foosball table and a games console. One of the residents had a bicycle in the garden and was reported to enjoy cycling. Residents reported to enjoyed home visits, day trips, going to a day centre, dancing, colouring, watching movies, getting out for lunch and visiting the local shops. One of the residents had a goal of employment and joining a charity shop to volunteer. Another wished to join a Christmas choir. There were six vehicles for residents' use in the centre, which enabled residents to pursue activities which were meaningful to them independently of one another.

Managers in the centre had completed training in a human-rights based approach in health and social care. Inspectors spoke with the deputy person in charge and they told inspectors that they now used the principles of Fairness, Respect, Equality, Dignity and Autonomy (FREDA). They described how they picked one of these principles and reflected on how they could use that to inform their practice for key working sessions with residents. This was also used at staff handovers each day to prompt staff to think about how they could use the principles in practice when they were supporting residents throughout the day. One member of the local management team spoke about how they had used FREDA principles to ensure they took a positive risk taking approach to restraint reduction for one of the residents.

Five of the residents had completed residents' questionnaires which had been sent out to the centre prior to the inspection taking place. Questionnaires look at residents' satisfaction at their home, their staff support, food, rights, complaints and visits. For the most part, residents indicated that they were happy with the service they were receiving. One resident voiced their wish to move on to another house. To gain further insight into the residents' views, inspectors viewed resident feedback which was in the annual review. This noted that residents were generally happy with their environment, their choices. One resident had indicated that they wished to live nearer to where they are from, while another wanted to move to a lower support centre. Residents wrote who they would speak to in the event of any concerns and those who had made complaints reported that they were happy with how the complaint was managed. One resident said that they would like there to be more activities in the centre. Another resident said that they didn't want to change

anything about the centre.

Interactions between staff and residents were noted to be warm and friendly and residents appeared comfortable in the company of staff. Due to the complex needs of residents, there were high levels of restriction in the designated centre. These were found to be assessed and regularly reviewed. Where possible, restrictions were reduced and there was evidence of restrictions being discussed with residents in addition to seeking consent for restrictions.

In summary, from what residents told us, what inspectors observed and from reviewing documentation, it was evident that residents in the centre were well-supported to pursue meaningful activities in their local community. The next two sections of the report present the inspection findings in relation to governance and management in the centre and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

Overall, inspectors found that the provider had suitable governance and management arrangements in place to monitor and oversee the quality and safety of care and support of residents in the centre. However, improvements were required in the accurate maintenance of records, risk management and staff training and development. These are outlined in the body of the report.

The provider had a clearly defined management structure in place which identified lines of authority and accountability. The person in charge was supported in their role by a senior deputy person in charge, a junior deputy person in charge and team leaders. Each of these grades had clear responsibilities and duties to manage, monitor and oversee care and support in the centre. There was a management presence in the centre seven days a week, with on-call arrangements in place for senior management where required. The provider had completed an annual review in line with regulatory requirements which included consultation with residents. Six-monthly unannounced provider visits had taken place. Inspectors viewed the two six-monthly unannounced visits which occurred in 2023. These were found to contain detail which did not pertain to this centre and documented some findings as repeated findings. However, discussions with the management team on the day of the inspection indicated that these had already been closed out. These indicated that the provider was self-identifying areas for improvement. Staff meetings took place on a regular basis and the agenda was resident-focused and included discussions on safeguarding, policies and procedures and support plants.

The provider had a number of quality assurance tools and processes in place to monitor and trend key service areas such as safeguarding, behaviours of concern, incidents and accidents and complaints. The person in charge used a governance matrix to identify trends, review actions to ensure ongoing progress with these actions. This was discussed between the person in charge and the person

participating in management each week. Compliance reports for all actions identified on audits, six monthly visits and inspections were kept in a central online system and reviewed on a weekly basis.

The provider had employed a person in charge who was suitably qualified and experienced to fulfill the requirements of their role. The person in charge had worked in the centre for a number of years and demonstrated their knowledge of each of the residents and their assessed needs and expressed preferences.

Inspectors found that the provider had ensured that the number, qualifications and skill mix of staff was appropriate to best meet the assessed needs of residents. There were planned and actual rosters in place and these were well maintained. Rosters indicated that while there were some staff vacancies on the day of the inspection, there were regular relief staff who completed shifts in the centre. This enabled residents to enjoy good continuity of care.

Inspectors viewed the training matrix for staff in the centre and found that staff had access to mandatory training in line with the provider's statement of purpose. These included fire safety, manual handling, safety interventions, safe administration of medication and food safety. However, there were some gaps noted in training sessions which were related to residents' assessed needs. These are outlined in Regulation 16: Staff training and development below. The management team had completed training on applying a human-rights based approach to health and social care. They were using FREDA principles to increase staff knowledge and awareness of promoting rights in the centre. Regular staff supervision took place in line with the provider's policy. A sample of minutes from meetings noted that these sessions were resident-focused and included discussions on training, competencies and feedback on performance. The person in charge reported that they played a mentoring role for staff to guide them through managing any incidents which had occurred in the centre.

Inspectors found that the maintenance of records required improvement in some areas of the designated centre. However, these gaps did not result in medium or high risk to residents and had been identified as an area requiring improvement in the provider's last six-monthly unannounced visit.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider made an application for renewal of registration for the designated centre to the office of the chief inspector. This included all information required by the regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had employed a person in charge who was suitably qualified and experienced in their role. They worked on a full-time basis and were supernumerary. The person in charge had worked in the centre for a number of years and it was evident that they knew residents and their preferences and assessed needs well.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the number, qualifications and skill mix of staff was appropriate to the assessed needs of the residents, the statement of purpose and the size and layout of the centre. Planned and actual rosters were well maintained. While there were vacancies in the house on the day of the inspection, continuity of care was ensured through the use of regular relief staff.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had completed mandatory training in a number of areas, as outlined previously. However some staff had not completed training in line with the provider's statement of purpose in order to be informed with skills and knowledge to best meet residents' assessed needs. For example, training in epilepsy management, in supporting residents with acquired brain injury and in feeding, eating, drinking and swallowing difficulties had been done by some staff, but a number of these were outstanding on the day of the inspection.

Judgment: Substantially compliant

Regulation 21: Records

While it was evident that care was delivered to a high standard, there were some gaps identified in documentation which did not pose a medium or high risk to residents. These were identified by the provider in the most recent six-monthly unannounced provider visit. For example, gaps were identified in the provider's six-monthly unannounced visit and gaps were identified in the signatures of financial records in line with the provider's policy. For example, in the report from the most

recent six-monthly unannounced visit, the auditor made reference to guardian ad litum in spite of this being a designated centre for adults with disabilities. Some findings were documented as repeated findings when they had already been closed.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to residents and other risks in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The management structure in the centre was clearly defined and identified lines of authority and accountability among the team. The provider had completed an annual review and six-monthly unannounced provider visits in line with regulatory requirements. The provider had systems in place to trend, analyse and track incidents in the centre and take required actions in a timely manner. Oversight of these systems was the responsibility of the person in charge in liaison with their line manager. Reports from the six-monthly unannounced provider visit contained some gaps. However this finding is addressed under Regulation 21: Records, as inspectors were assured by the governance and management arrangements in the centre which was evident on the day of the inspection.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had a Statement of Purpose which contained information set out in Schedule 1 of the regulations.

Judgment: Compliant

Quality and safety

Inspectors found that residents were supported and encouraged to engage in activities of their choosing and to have a good quality of life. There was evidence of consultation and residents had access to healthcare services and opportunities for social engagement. Improvements were required in risk management.

The provider had a number of policies in place to guide staff practice in relation to managing complex behaviours. These included a behaviour management policy and procedure, procedures on the use of restrictive procedures and policy and procedure on the use of safety interventions. A number of residents in the centre presented with complex behaviour support needs. Residents had access to a behaviour therapist, a psychologist and a psychiatrist. The behaviour specialist was present in the centre twice a week. Staff had clear guidance on proactive and reactive strategies to use with residents and for residents who had higher behaviour support needs, there were multi-element behaviour support plans in place. Individual risk management plans provided further guidance on personal and protective equipment which staff could use which was specific to each residents' assessed needs.

It was evident that residents' rights were considered as part of their behaviour support. For example, one resident had a contract in place and a chart was on their wall in their apartment. This noted that the resident had not had any behavioural incidents in over 60 days. This was something which the resident enjoyed telling visitors to the centre. Consultation had taken place with other residents in relation to restrictive practices and in the event physical holds were used, a debrief with residents and staff occurred. Restriction reduction plans were reviewed in real time due to the variable presentations of residents. For example, there was evidence on an incident report of staff engaging with a resident and explaining why they were putting an additional restriction in place due to their presenting behaviour. For another incident, it was noted that the resident was discussing the level of behavioural incident which they were engaging in and its potential impact on their daily planner.

There were a high level of notifications on allegations of abuse received from the designated centre in the twelve months prior to the inspection taking place. Some of these were peer-to-peer incidents. Inspectors found that these were documented, reported and investigated in line with national policy and notified to the Office of the Chief Inspector within required time lines. A safeguarding log was in place in addition to a centre-specific safeguarding plan. This plan outlined potential vulnerabilities in the centre and control measures in place. A sample of intimate and personal care plans were reviewed and found to be suitably detailed to guide staff practice and to ensure that residents' rights to privacy and bodily integrity were upheld.

Residents were supported to control and retain access to their personal possessions in line with their individual risk management plans and court directions. Residents had access to facilities to wash their clothes in the centre if they wished to do so. Residents' money management skills and required levels of support were assessed and a money management plan was in place for each resident. It was evident that residents were supported to develop understanding and skills in relation to their finances. For example, in one resident's apartment, there was a visual support on

their wall outlining their daily budget and their choices which they could make while keeping within that budget. A money management plan was in place. Financial records of spending and income were kept and audited regularly to ensure residents' finances were monitored and safeguarded. An assets book was also in place for each resident to catalogue their personal possessions.

It was evident in the centre that residents were supported to participate in activities in accordance with their interests. Residents had access to their own transport and staffing allocations meant that residents could get out each day to areas of their choice. One resident was engaging with the provider's outreach department to seek employment. Another resident went to a local gym and another regularly went swimming. Residents were provided with supports to develop and maintain relationships with those important to them.

As outlined in the opening section of the report, the provider had made significant improvements to the premises since the last inspection. This included painting, bathroom upgrades, replacement of some flooring and repairing some cupboards and counter tops in one residents' apartment. Sound proofing had been installed on some walls at the request of one of the residents. Overall, the centre was found to be in a good state of repair. Residents' areas were personalised. While some areas of the centre had high levels of restrictions in place which took from the homely feel of these areas, this was assessed on an ongoing basis to ascertain if reduction plans could be put in place.

The registered provider had a risk management policy in place which met regulatory requirements. There were risk management systems in place to ensure that risks were identified, assessed, managed and reviewed, including a system for responding to emergencies. Each resident had their own individual risk management plans in place which identified control measures for staff to minimise the impact of these risks. Where adverse incidents had occurred, these were documented using the provider's online system. For the most part, inspectors found these reports to be suitably detailed and each incident was reviewed by a member of management within the house. Some gaps were noted in recording physical interventions. For example, one incident did not record the length of time which a resident was in a hold for, another did not accurately record the number of restraints used while another had a gap of two days in the time it was reported. The risk register required review to ensure that it was reflective of the risks presenting and of the number of incidents. This had been identified in the provider's most recent six-monthly review.

Regulation 12: Personal possessions

Residents were supported to retain access to and control over their personal belongings in line with their assessed needs and their legal agreements. Within the centre, residents had ample space to store their personal belongings. They retained control over their clothes and there were facilities to launder their clothes within the centre. Residents' access to and control of their finances was assessed and clear

money management plans were in place. There were systems in place to support residents to maintain oversight of their finances.

Judgment: Compliant

Regulation 13: General welfare and development

Residents living in the centre had opportunities to engage in activities of their choice in the community. Residents were supported to do courses to increase their employment options. One resident was being supported to apply for voluntary roles to build up their experience for a job. Other residents were supported to go out walking, to the gym, to shops and swimming. Residents had access to a games room to the rear of the house. Residents were supported to maintain contact and sustain relationships with those important to them.

Judgment: Compliant

Regulation 17: Premises

As outlined in the opening section of the report, there had been improvements in the premises since the last inspection. Inspectors found that the premises was now in a good state of repair and maintained in a timely fashion. Some furniture had been replaced in addition to flooring, painting and a bathroom was refurbished. Inspectors found the centre to be warm and well suited to residents' assessed needs.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a residents' guide which met regulatory requirements.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register required review to ensure that it was reflective of the risks

presenting and of the number of incidents. This had been identified in the provider's most recent six-monthly review. Some documentation relating to incidents and accidents required improvement. For the most part, reports were found to be suitably detailed and each incident was reviewed by a member of management within the house. However, there were some gaps were noted in recording physical interventions. For example, one incident did not record the length of time which a resident was in a hold for, another did not accurately record the number of restraints used while another had a gap of two days in the time it was reported.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Inspectors found that staff were trained in responding to behaviours of concern and in supporting residents to manage their behaviour in line with the provider's policy. This included the use of de-escalation and safety interventions. Where any physical holds were required, these were clearly documented and reviewed with both the resident and staff following any incidents. It was evident that the provider was promoting residents' right to be consulted with and given information about their behaviour support plans, restrictive practices and independence. There were a high level of restrictions in place in the centre. These were logged and regularly reviewed.

Judgment: Compliant

Regulation 8: Protection

As outlined above, there were a high level of notifications relating to safeguarding from the centre. Some of these incidents involved peer to peer issues. A safeguarding log was in place in addition to a centre-specific safeguarding plan. This plan outlined potential vulnerabilities in the centre and control measures in place. A sample of intimate and personal care plans were reviewed and found to be suitably detailed to guide staff practice and to ensure that residents' rights to privacy and bodily integrity were upheld.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Broadleaf Manor OSV-0003397

Inspection ID: MON-0032477

Date of inspection: 14/11/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in Charge (PIC) shall conduct a review of all Individuals assessed needs as and where required, update the Centre's Statement of Purpose to ensure it is reflective of the Centre Specific Training required. 2. Following the review, the PIC, shall check the Centre's Staff Team and training records to ensure all staff have the necessary Centre Specific Training required to support the Service Users in line with their assessed needs. 3. The PIC will ensure all staff are provided with training to support Individuals with regards to specific health needs such as Epilepsy Management and Educational Training will be provided in regards understanding Acquired Brain Injury.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. The Person in Charge (PIC) will ensure all records and documentations are maintained to a high standard with regular checks conducted by the Centre's administrator. 2. As a quality improvement initiative, a senior led review of Centre Specific Monthly Assurance Reports and the providers unannounced six-monthly report will be conducted to ensure improvements are made and relevant documents updated as required, so as to ensure corrective actions are SMART and are concise in addressing the key findings.	

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

1. The Person in Charge (PIC) shall conduct a review of the Centre's risk register to ensure all risks pertaining to the quality and safety of the Centre is identified and updated where required.

2. Where required, the Behavior Specialist shall oversee a review of incident reports in conjunction with the PIC to ensure all relevant information is documented and well written. Additional training will be provided to the staff team in regards report writing skills.

3. Any updated risk management plans or risk registers shall be presented to the staff team and briefed on the risks identified and the relevant controls in place.

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 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	19/01/2024
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	21/01/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Substantially Compliant	Yellow	31/01/2024

	ongoing review of risk, including a system for responding to emergencies.			