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:	Avalon House
Name of provider:	Health Service Executive
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	12 April 2022
Centre ID:	OSV-0003694
Fieldwork ID:	MON-0027904

About the designated centre

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

This designated centre provides 24 hours full-time residential care and accommodates seven adults both male and female over the age of eighteen with an intellectual disability. The centre is a large detached bungalow a few kilometres outside the nearest town. The centre comprises fifteen rooms including two small storage rooms and a lobby area. There is a kitchen, dining room, sitting room, utility room and seven bedrooms, all with en-suite facilities. There is one separate bathroom and one wheelchair accessible toilet. The centre has a large garden and patio area at the back of the house. It has its own transport; a wheelchair accessible vehicle and a people carrier. The person in charge works full-time in this centre and the staff team includes both nurses and health care assistants. Staff provide support to residents during the day and at night.

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 12 April 2022	10:00hrs to 17:30hrs	Julie Pryce	Lead
Tuesday 12 April 2022	10:00hrs to 17:30hrs	Florence Farrelly	Support

What residents told us and what inspectors observed

This was an announced inspection conducted in order to inform the decision of the chief inspector on the application from the provider to renew the registration of the designated centre, and to assess the compliance with the required actions from the previous inspection of October 2021.

Overall, significant improvements had been made by the provider since the last inspection, and many of the failings identified then had been addressed. However, further improvements were required in the areas of governance and management, safeguarding of residents, and the rights of residents to enjoy a quiet home life in compatibility with others. These issues are discussed later in the report.

On arrival at the house, inspectors observed that current public health requirements were being adhered to, and that hand sanitisation and personal protective equipment (PPE) was immediately available. Following a brief introductory meeting, the inspectors conducted a 'walk around' of the centre. The designated centre was a pleasant and homely environment, with several communal areas, some of which had been adapted to their best advantage, so that there were areas for hobbies or beauty care, television watching and relaxing which residents could enjoy.

All areas of the home were visibly clean, and there was a homely and person centred atmosphere. Personal artwork was seen on the walls, person centred items were seen throughout, and various hobbies and interests had been facilitated in different locations of the home.

There was a spacious kitchen and dining area, a comfortable living room, and functional outside areas to the rear and side. Each resident had their own bedroom, and the inspectors visited the rooms of those residents who were comfortable with this. The rooms were nicely furnished and decorated, and personal items were evident throughout. There was easy read information including pictures and simple wording placed strategically throughout the house.

When inspectors arrived to the centre most of the residents had gone out to various activities, those who were at home explained to inspectors that they had chosen to stay at home that day, and some showed a particular interest in the visit of the inspectors, which they had been made aware of by the staff and person in charge in advance of the inspection.

As residents returned home during the course of the inspection, they each chose their preferred areas and activities, and were observed by the inspectors to be relaxing and enjoying their home. Staff were seen to be supporting residents in a caring and respectful manner, and it was evident that residents were relaxed with them, and enjoyed their company. Some people had a snack in the kitchen area and a chat with staff, others went to their rooms or began activities, such as colouring, and some people enjoyed the small but comfortable tv area, which was furnished

with comfortable sofas and chairs.

Some residents had a chat with inspectors, and described the activities of their day. One person told the inspector that they had been shopping, and happily described their purchases. Others said that they were content in their home, and that they liked the staff. They explained that they would know who to go to if they had any concerns.

Residents had connections with their local community, and some were involved in groups or hobbies in the community. A local artist is creating a statue for their garden, and residents were in the process of voting on the statue that they would prefer.

Some of the residents and their families had completed questionnaires in advance of the inspection. Family members were very complimentary about the care their relatives received. They praised the management of the recent public health crisis highly, and also commented on how well managed residents' healthcare needs were. Any areas of concern raised in the questionnaires had been identified by the provider, and steps were being taken to address them.

In summary, the inspector found that residents were supported to have a good quality of life for the most part. The systems and arrangements that the provider had put in place in this centre ensured that the residents were supported and encouraged to choose how they wished to spend their time and they were involved as much as possible in the running of their home.

However, despite the substantial improvements that had been made, there was an on-going issue whereby the behaviour of some residents was having a significant impact on others, albeit much reduced, safeguarding issues and issues in relation to compatibility found on the previous inspection had not been fully addressed.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

The inspectors found a clearly defined management structure in place with clear lines of accountability. The provider had made arrangements to ensure that key management and leadership roles were appropriately filled. There was a person in charge in position at the time of the inspection who was appropriately skilled, experienced and qualified. They were knowledgeable about the needs of residents, showed clear oversight of the centre and demonstrated an understanding of the importance of quality of care and support. They were well supported by the area management team, and there were various management teams in place, including a team responsible for the response to the recent pandemic and on-going public

health situation.

The provider had put systems in place to ensure the staff team were appropriately skilled and supported. The number and skills mix of staff was appropriate to meet the needs of residents, and improvements had been made in relation to the requirement for nursing cover, which was now well managed. There was a core team of staff, all of which were familiar to residents. There was a nurse on duty at all times, and staffing numbers were sufficient on a daily basis to meet the needs of residents. The person in charge had access to additional staff should the need arise, for example to facilitate appointments or additional activities.

Staff were in receipt of regular training which was found to be current and relevant, and was overseen by the person in charge. Staff had received all mandatory training, and some additional staff received training in relation to administering rescue medication. This additional training meant that outings were not dependent on the availability of nursing staff who previously were the only staff responsible for administering this medication, now that more staff were trained this increased the opportunities for outings for some residents.

A sample of staff files was reviewed, and the files contained all the information required by the regulations. Staff were knowledgeable in relation to the needs of residents and were observed to be providing care and support in accordance with their identified needs.

There were various strategies in place to ensure effective communication with staff. Regular team meetings were held, and issues raised in audits and in the person centred planning process were discussed at these meetings. A daily handover sheet was prepared and discussed, and clear records of keyworker sessions with residents were maintained and shared.

The provider had completed the required reviews and reports focusing on the quality and safety of care provided in the centre in accordance with the regulations. An annual review of quality and safety of care and support in the centre had been completed, and this was a meaningful document which took account of the requirements of the regulations, including the requirement to elicit the views of residents and their representatives. An action plan resulting from this report included reference to fulfilling the required actions from the last inspection of the centre, and monitoring of progress was clear. Substantial improvements had been made, including in the personal planning system, risk management and record keeping.

However, not all of the required actions had been implemented. There was an on-going issue whereby the behaviour of some residents was continuing to have a negative impact on others, and there was insufficient evidence that this risk had been mitigated. Although reported incidents had reduced significantly due to various interventions, there remained a risk to residents. This issue had been identified in previous inspections, and proposals had been submitted in response to these findings. These included, sourcing of alternative accommodation, and more recently, an adaptation of the structure of the centre so as to provide a self-contained area

for one of the residents. The intended outcome was to provide separate accommodation whilst supporting residents to continue to remain in their home. At the time of the inspection, little progress had been made towards any of the suggested solutions.

In addition, an allegation of abuse raised in May 2020 had not been resolved. While the provider had put steps in place to begin the investigation it had not commenced at the time of this inspection and there was insufficient evidence that residents were safeguarded in regard to this matter. Both these matters were discussed with the management team on the day of inspection with a view to ensuring there would be a timely resolution.

A suite of audits of practice was in place and had been undertaken, although minor improvements were required in the frequency of some of the audits in order to comply with the centre's policy. This suite of audits included fire safety, medication management, residents' finances and person centred planning. A review of actions required form these audits found them to be effective, for example there was evidence that learning from identified medication errors had been put into practice.

Registration Regulation 5: Application for registration or renewal of registration

The application to renew the registration of the centre had been made on time, and all the required documents had been submitted.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was appropriately skilled, experienced and qualified, had a detailed knowledge of the support needs of residents and was involved in oversight of the care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

The staffing numbers and skills mix were appropriate to the number and assessed needs of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were in receipt of all mandatory training, and additional training specific to the needs of residents, and were appropriately supervised.

Judgment: Compliant

Regulation 21: Records

All the required records were maintained by the provider.

Judgment: Compliant

Regulation 22: Insurance

Appropriate insurance was in place.

Judgment: Compliant

Regulation 23: Governance and management

The provider had completed the required reviews and reports focusing on the quality and safety of care provided in the centre, an annual review of quality and safety of care and support in the centre had been completed. An action plan resulting from this report included reference to fulfilling the required actions from the last inspection of the centre, and monitoring of progress was clear. Substantial improvements had been made, including in the personal planning system, risk management and record keeping.

However, not all of the required actions had been implemented. There was an on-going issue whereby the behaviour of some residents was continuing to have a negative impact on others, and there was insufficient evidence that this risk had been mitigated. This issue had been identified in previous inspections, and proposals had been submitted in response to these findings. At the time of the inspection, little progress had been made towards any of the suggested solutions.

In addition, an allegation of abuse raised in May 2020 had not been resolved. While the provider had put steps in place to begin the investigation it had not commenced at the time of this inspection and there was insufficient evidence that residents were safeguarded in regard to this matter.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose included all the required information and adequately described the service.

Judgment: Compliant

Regulation 31: Notification of incidents

All required notifications had been made to HIQA within the required timeframes.

Judgment: Compliant

Regulation 4: Written policies and procedures

All the policies required under Schedule 5 were in place and had been reviewed within the required timeframe.

Judgment: Compliant

Quality and safety

Significant improvements had been made in the organisation of documentation in the centre, and the information in personal plans was now well organised and readily accessible. There was a system in place to ensure that all records were up to date, including a recording sheet to indicate where updates were required.

Each resident had a personal plan which was based on an assessment of needs, and all areas of the plans were detailed and current. They included personal care,

communication and both physical and mental health needs.

Healthcare needs were well addressed, and there was evidence of response to changing needs, and of health promotion. There was evidence of the input of the relevant members of the multi-disciplinary team, and that the recommendations of these professionals was incorporated into the healthcare plans. These plans contained detailed guidance for staff, and were under regular review. Implementation of the plans was recorded.

Residents were in receipt of a healthy and varied diet, with access to snacks and meals in accordance with their assessed needs and preferences. Where a resident's diet was being monitored, there were appropriate foods freely available, and their intake was monitored and documented appropriately.

Each resident had a 'hospital passport' which outlined their individual needs in the event of a hospital admission. These included sufficient detail as to inform receiving healthcare personnel about the individual needs of each resident.

Where residents required behaviour support there were detailed plans in place which outlined both proactive and reactive support needs. The plans included detail as to the antecedents for incidents of behaviours of concern, and detailed guidance for staff as to how to manage each stage of escalation so as to reduce both the incidence and the severity of behaviours. Staff were required to sign these plans to indicate that they had read and understood the information, staff spoken with were knowledgeable about the information, and their role in implementing the plans. It was clear from a review of incident reports that the number of incidents had reduced significantly since the last inspection.

However, the incidents of behaviour of some residents that had an effect on others had not been completely ameliorated, and the issue of compatibility had not been fully managed, as discussed earlier in this report.

Person centred plans were based on monthly 'keyworker' meetings, and goals had been set with residents, for example holidays or outings. There were multiple examples of the involvement of residents in their local community, including various hobbies and activities. In addition, weekly resident meetings were held, at which activities, meal plans and preferences were discussed.

There was a section in each personal plan in relation to communication, which outlined both their ways of communicating, and guidance for staff as to the best ways to communicate with them. Staff were observed to be utilising this information, and communicating effectively with residents.

Residents were supported to maintain contact with families and friends, and were supported to receive visitors, and to make visits to their families. They had access to the internet and phone, and these were strategies implemented during recent community restrictions.

Safeguarding of residents was monitored, and there were safeguarding plans in place relating to identified issues. However, an investigation of an allegation of

abuse made in May 2020 had not yet commenced, and there was insufficient evidence that this matter was effectively managed. In addition, as previously discussed, the behaviour of one of the residents posed a safeguarding risk to others.

Medications were well managed and safely stored. Documentation was in place for each resident, medications were safely stored, and administration practice was appropriate. Effective stock control practices were in place and staff were knowledgeable in relation to the medications of each resident.

Effective fire safety precautions were in place, including fire detection and containment arrangements, fire safety equipment and fire doors. A detailed personal evacuation plan was in place for each resident Staff could readily describe the actions they would take in the event of an emergency, and had all been involved in fire drills. These fire drills took place regularly, and included night time drills. The documentation of these fire drills, together with discussion with staff members, demonstrated that all residents could be effectively evacuated in a timely fashion in the event of an emergency.

The risk management policy had been recently reviewed, and included all the requirements of the regulations. All identified risks in the centre had been assessed and risk rated appropriately, and there was a risk management plan in place for each, which was kept under regular review. A risk which was found to have been insufficiently managed at the previous inspection now had an appropriate management plan in place.

Infection prevention and control had been given priority by the provider over recent times. Cleanliness and hygiene were maintained to a high standard, and various checklists were in place to ensure ongoing good standards. There was a contingency plan in place in the event of an outbreak of an infectious disease, and this had been successfully implemented during an outbreak of COVID-19. Following the outbreak a comprehensive review of the implementation of this plan had been conducted, and any learning clearly identified.

The rights of residents were respected and upheld for the most part. There were options available to them in terms of activities and trips, and an advocate was available to them should they require one. However, whilst plans were outlined to the inspectors in relation to managing the compatibility of residents, and the effect of the behaviour of residents on others, these issues had not been addressed, and had been on-going for an unreasonable length of time.

Regulation 10: Communication

Residents were supported to communicate, and information was made available to them.

Judgment: Compliant

Regulation 11: Visits

Visits were facilitated and welcomed.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had sufficient storage for their personal possessions, and personal effects were evident throughout the centre. A record was kept of each resident's personal items.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were provided with appropriate care and support in accordance with their assessed needs and preferences.

Judgment: Compliant

Regulation 17: Premises

Premises were adequately laid out and equipped to meet the needs of residents.

Judgment: Compliant

Regulation 18: Food and nutrition

There was adequate food and nutrition in accordance with the needs and preferences of residents.

Judgment: Compliant

Regulation 20: Information for residents

The provider had prepared a guide in respect of the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk management policy in place which included all the requirements or the regulations. There was a risk assessment and management plan in place for all identified risks, including risk relating to COVID-19.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate infection prevention and control practices were in place.

Judgment: Compliant

Regulation 28: Fire precautions

There was appropriate fire equipment including fire doors throughout the centre, and evidence that residents could be evacuated in a timely manner in the event of an emergency.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Structures and procedures were in place to ensure the safe management of medications.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There was a personal plan in place for each resident in sufficient detail as to guide practice, including detailed healthcare plans, which had been regularly reviewed.

Judgment: Compliant

Regulation 6: Health care

There was a high standard of healthcare, and there was a prompt and appropriate response to any changing conditions.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were detailed behaviour support plans in place, and evidence that these were implemented appropriately.

Judgment: Compliant

Regulation 8: Protection

Whilst safeguarding plans were in place for some identified issues, residents were not safeguarded against the effects of behaviours of concern in the centre, and an allegation of abuse had not been investigated.

Judgment: Not compliant

Regulation 9: Residents' rights

Whilst there was an ethos of promoting and respecting the rights of residents for the most part, the rights of residents to live in compatibility with others had not

been addressed, and an allegation of abuse had not been investigated.
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 (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	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Avalon House OSV-0003694

Inspection ID: MON-0027904

Date of inspection: 12/04/2022

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
There are detailed positive behavioural support plans outlining pro active and reactive strategies to guide staff in their actions and interventions in responding to behaviours of concern by residents
Staffing numbers and the skill mix rostered takes account of individual resident's needs to ensure postive outcomes for all residents on a daily basis.

The PPIM and the PIC have explored different options to ensure compatibility among all residents living in the centre. Each resident has expressed the wish to continue living in their current home.
To ensure the physical environment supports compatible living arrangements management are working with estates to ensue that building plans are progressed. A work plan schedule with associated timelines for the proposed works from design through to completion of the construction phase is as follows;
1. Design Stage (already complete) 4 weeks.
2. Pre-planning Stage. 2 weeks.
3. Planning Stage. 12 weeks.
4. Fire Safety, Disability Access Certificate Stage (including preparation). 8 weeks.
5. Tender Stage including cooling off and appointment of contactor
(run parallel to stage 4 above)
6. Commencement Notice. 2 weeks.
7. Construction Stage. 16 weeks
8. Sign off on completion. 1 week
Completion date for same is agreed as 30/04/2023.

In the meantime the PIC will continue to engage with all residents to ensure their preferred choice or options in relation to where they wish to live are facilitated to ensure compatibility and quality of life as vacancies arise across the service.

An external cabin awaiting required certifications will also provide extra communal space to all residents and create more quiet areas where residents will have more personal space in the centre.
Preparatory works are underway to secure a fire safety certificate and a disability access certificate.
The timelines associated to obtain the required certification is as follows:

1. Prepare and submit both applications 4 weeks.
2. Processing time by the decision making body to decide on both applications is 8 weeks.

Total timeframe is 12 weeks with an end date of 31/08/2022 for completion and for this cabin to be available for use by all residents.
The PIC and PPIM continue to review incident reports on a monthly basis to identify any learning both on an individual or collective basis. The number of behavioural incidents continues to decrease as a result of mitigation measures implemented and quality initatives adopted to ensure the behaviour of any resident does not have a negative impact on others in their home environment.
In regards to the allegation of safeguarding raised in May 2020, there are safeguarding plans developed in line with the centre's Safeguarding policy.The PIC manages the working roster to ensure no lone working occurs. An agreed Terms of Reference for the investigation is in place and the Provider Representative is working to conclude the investigation. Any findings or recommendations from the investigating team will be implemented.
Staff have completed refresher training in safeguarding and all staff are aware of the Open Disclosure Policy.
Individual staff supervision meetings take place on a regular basis with all staff.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
There are detailed positive behavioural support plans plans outlining pro active and reactive strategies to guide staff actions and interventions in responding to behaviours of concern by residents.

Staffing numbers and the skill mix rostered takes account of individual resident's needs to ensure postive outcomes for all residents on a daily basis.

The PPIM and the PIC have explored different options to ensure compatibility among all residents living in the centre. Each resident has expressed the wish to continue living in their current home.

To ensure the physical environment supports compatible living arrangements management are working with estates to ensure that building plans are progressed for a

one bedroomed self contained apartment. There is a work plan schedule with associated timelines for with the proposed works from design through to completion of the construction phase in place for this extension to support a compatible living environment.

In regards to the allegation of safeguarding raised in May 2020, there are safeguarding plans developed in line with the centre's Safeguarding policy.The PIC manages the working roster to ensure no lone working occurs. An agreed Terms of Reference for the investigation is in place and the Provider Representative is working to conclude the investigation. Any findings or recommendations from the investigating team will be implemented.

Staff have completed refresher training in safeguarding and all staff are aware of the Open Disclosure Policy.
Individual staff supervision meetings take place on a regular basis with all staff

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents rights is an agenda item at each residents' meeting and Advocacy Services are available as required.

The PPIM and the PIC have explored different options to ensure compatibility among all residents living in the centre. Each resident has expressed the wish to continue living in their current home at the present time. In the meantime the PIC will continue to engage with all residents to ensure their preferred choice or options in relation to where they wish to live are facilitated to ensure compatibility and quality of life as vacancies arise across the service.

To ensure the physical environment supports compatible living arrangements management are working with estates to ensure that building plans are progressed for a one bedroomed self contained apartment. There is a work plan schedule with associated timelines for the proposed works from design through to completion of the construction phase in place for this extension to support a compatible living environment.

The PIC and PPIM continue to review incident reports on a monthly basis to identify any learning both on an individual or collective basis. The number of behavioural incidents continues to decrease as a result of mitigation meaures implemented and quality initatives adopted to ensure the behaviour of any resident does not have a negative impact on others in their home environment.
In regards to the allegation of safeguarding raised in May 2020 there are safeguarding plans developed in line with the centre's Safeguarding policy.The PIC manages the working roster to ensure no lone working occurs. An agreed Terms of Reference for the investigation is in place and the Provider Representative is working to conclude the investigation. Any findings or recommendations from the investigating team will be

implemented.

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.	Not Compliant	Orange	30/04/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2023
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	31/10/2022

Regulation 09(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.	Not Compliant	Orange	30/04/2023