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:	36 Elmwood Park
Name of provider:	St Michael's House
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	04 October 2023
Centre ID:	OSV-0002392
Fieldwork ID:	MON-0041645

About the designated centre

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

36 Elmwood Park is a designated centre operated by St. Michael's House. It provides residential care and support to adults with an intellectual disability. Residents with additional physical or sensory support needs can be accommodated in this designated centre. The centre can support residents with additional support needs such as alternative communication needs, specialist diet and nutrition programmes and residents with well managed health conditions such as epilepsy or diabetes. The centre can also support people with dual diagnosis intellectual disability and mental health diagnosis. The centre offers support to residents in activities of daily living including support in personal care, meal preparation, organising, planning and participating in social activities. Multi-disciplinary support is available to assess and support residents' changing needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 4 October 2023	09:20hrs to 16:20hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection of the designated centre, scheduled to assess the provider's ongoing regulatory compliance. Overall, the inspector found that residents in this centre were in receipt of a person-centred and safe service.

The designated centre is located in a busy town close to many amenities such as shops, parks and community centres. The centre is registered to accommodate six residents and there was one vacancy at the time of inspection. The inspector had the opportunity to meet four of the residents who were living there. Conversations with residents and staff, a walk around of the premises and a review of the documentation were used to form judgments on the quality and safety of care in the centre.

On arrival, the inspector saw that the centre was well maintained both on the exterior and inside. The inspector was greeted by a staff member who informed her that she was assisting a resident with their morning routine. The entrance hallway was seen to be very clean and tidy. The inspector met one resident who was waiting for their bus to attend day service. This resident did not engage with the inspector but was seen to be comfortable and responded to the staff member's interactions. Later in the day, the inspector saw this resident engaging in their preferred activities in the kitchen of the centre. The resident appeared comfortable and relaxed in their home.

The person in charge attended the centre and an opening meeting was completed with them and with the staff present. The inspector was informed that it had been a difficult few months in the centre as one resident had sadly passed away and was much missed by the other residents and staff. The person in charge spoke about the changing needs of some of the current residents due to age-related changes. A service review was underway at the time of inspection to inform the future direction of care and support being provided in the designated centre. This will be discussed later in the report.

The person in charge informed the inspector that they had plans to support another resident to attend a healthcare appointment later that day. This resident was in bed when the inspector arrived but the inspector had the chance to meet them when they woke. The resident told the inspector that they had just had their hair washed and that they were going to see the doctor. They seemed very comfortable in their home. Staff were seen to interact with the resident in a gentle and kind manner, assisting them with their shoes and with getting ready for their appointment. Staff told the inspector that this resident had made good links in their community, and in particular, enjoyed visiting a local coffee shop regularly to chat to staff there and to have a coffee.

Another resident was in bed when the inspector arrived. Staff informed the inspector that they followed a behaviour support plan to assist this resident in their morning

routine. The inspector saw that staff implemented the proactive strategies in this plan when the resident woke up. Their interactions were seen to be quiet and gentle and contributed to a low arousal environment.

Two other residents were at community activities and day service when the inspector arrived. Unfortunately, the inspector did not have the opportunity to meet one of these residents as they had not returned from day service by the completion of the inspection. Staff told the inspector that one resident was in receipt of individualised support in the evenings. They reported that this had a positive impact for the resident as they were engaged in a great variety of community based activities including going to the local gym and for walks. Staff reported that this was supporting the resident's physical and emotional health. Additionally, staff felt that the increase in individualised support had resulted in a reduction of safeguarding incidents in the centre.

The inspector met the remaining resident when they returned from a community based art class. This resident told the inspector that they had lived in the designated centre for many years and that they felt well supported by the staff. They said that they were aware of how to make a complaint and felt that their rights were well respected.

A walk around of the designated centre was completed with the person in charge. The inspector saw that the house was very clean and was generally well-maintained. Residents had access to their own individualised bedrooms as well as shared living rooms, a kitchen, utility and three bathrooms. The centre was homely and comfortable. Furniture was well maintained and aids and appliances were in good working condition. However, the inspector was told that only one of the bathrooms had a shower that was accessible to all of the residents. The downstairs bathroom consisted of a large accessible wet room with a shower and hydro bath. This bathroom was the preferred bathroom for four of the five residents due to its accessibility.

Upstairs there were two more bathrooms, both of which contained a shower and one of which contained a bath. However, both of these showers were inaccessible to the residents due to their assessed needs in mobility. This required review by the provider to ensure that the bathrooms were suitable to meet the needs of the residents.

The inspector also saw that some of the kitchen cabinets were damaged and that the laminate cover was peeling away. The kitchen countertop also required repair. This was known to the provider and the inspector was told that it was on a schedule of works to be completed. There were a number of restrictive practices in place in the kitchen due to the assessed needs of one resident. These will be discussed in the "quality and safety" section of the report.

The inspector saw residents coming and going from the centre both independently and with staff support during the course of the day. Overall, the inspector saw that residents were happy in their home and were living in a clean, safe and homely environment. Residents were in receipt of care that was person-centred and that

was endeavouring to ensure that their needs and wishes were respected.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. The inspector found that there were effective management systems in place which were ensuring the delivery of good quality care to the residents.

There were clear lines of authority and accountability in the designated centre. The centre was staffed by a team of social care workers, several of whom had worked in the centre for many years and knew the residents well. There was one part time social care worker vacancy. This vacancy was filled by a small panel of regular relief staff. This was supporting continuity of care for the residents.

The centre was run by an experienced person in charge. They reported to and were supported in their role by a service manager. Staff spoken with were clear on their roles and responsibilities and of how to escalate concerns or risks through the chain of command to the provider level.

The staff team were in receipt of regular supervision, support and training. A training matrix was maintained for the centre which showed a very high level of compliance with mandatory and refresher training. There was a gap identified whereby one relief staff required refresher training in several areas. The inspector was told that this had been identified and that there was a plan in place to address this. Staff reported that they felt well supported in their roles.

There were a suite of audits in place including six monthly unannounced visits and an annual review of the quality and safety of care. These audits were completed in consultation with the residents and their representatives. The audits identified risks and set out action plans to address these.

The provider had effected a complaints policy along with an accessible complaints procedure. Residents spoken with were well-informed regarding the complaints procedure and were aware of how to make a complaint should they wish to do so.

The policies in the centre were reviewed however many of these were found to be out-of-date. The inspector checked with the service manager who informed her that it was known to the provider that two policies were out-of-date and that these were under review at the time of inspection.

Overall, the inspector found that the management systems were effective in

ensuring good quality care was delivered to the residents.

Regulation 15: Staffing

Staffing levels in the designated centre were maintained in line with the statement of purpose. The number and qualifications of staff were suitable to meet the assessed needs of the residents. There was one part time social care worker vacancy at the time of inspection. This vacancy was filled by a small panel of regular relief staff which was supporting continuity of care for the residents. Many of the staff had worked in the designated centre for a long period of time and knew the residents and their needs and preferences well.

Judgment: Compliant

Regulation 16: Training and staff development

There was generally a high level of compliance with mandatory and refresher training in the centre. The inspector saw that all staff were up-to-date in training in first aid and children first. One regular relief staff required refresher training in several areas including infection prevention and control, fire safety and safeguarding. The person in charge was aware of this and had a plan in place to ensure that training was completed in the coming weeks.

Staff in this centre were in receipt of regular support through monthly staff meetings and regular one to one supervision with the person in charge. Staff reported that felt well supported in their roles and were confident in escalating any issues or risks through the management systems.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were clearly defined lines of authority and accountability in the designated centre. The centre was run by a person in charge who was supported in their role by a service manager. The person in charge and service manager were well informed regarding the residents' needs and the presenting risks in the centre.

At the time of inspection, a service review was underway to inform and plan for the model of care in the designated centre into the future. The managers had identified that, due to the changing needs of the residents, a change in service delivery may be required and so this was being explored and discussed to ensure that the centre

could continue to meet the needs of the residents in a manner that best upheld their rights.

There were a series of audits in place in the centre which were effective in identifying risks in the centre. The annual review and six monthly audit had been completed in consultation with residents, staff and families where appropriate. These audits reflected the stakeholders' views on the quality of service and set out SMART action plans to address risks where required.

Staff in this centre were performance managed and facilitated to raise concerns about the quality and safety of care provided to residents.

Judgment: Compliant

Regulation 34: Complaints procedure

There were no open complaints in the centre at the time of inspection. A record of previous complaints made by residents was maintained. The inspector saw that residents were supported to make complaints and that these were responded to and resolved in line with the complaints policy.

The complaints procedure was displayed in the centre. Residents spoken with were informed of how to make a complaint and felt that they were listened to when they did express a complaint.

The inspector saw that residents had also been supported to give feedback to the provider on the accessibility of the complaints form in order to drive improvement in this area.

Judgment: Compliant

Regulation 4: Written policies and procedures

The schedule 5 policies maintained in the centre were reviewed on the day of inspection. The inspector saw that many of these policies were out of date. Staff told the inspector that more up-to-date versions of the policies were available on the intranet however the intranet was inaccessible on the day of inspection.

The inspector contacted the service manager who informed her that there were two policies which had not been reviewed within the past three years as required by the regulations. These were the provider's policies on admissions and communication. The inspector was told that these were under review by the provider.

Judgment: Substantially compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. Overall, the inspector found that residents felt safe in their home and were in receipt of a good quality service. There were some areas for improvement required to the fire evacuation plans, accessibility of showers and the consultation with residents regarding medications and restrictive practices.

The inspector completed a walk-through of the designated centre and saw that it was clean and generally well-maintained. Residents had access to ample communal and private spaces. There were some improvements required to two upstairs showers to ensure that these were accessible. Additionally, it was known to the provider that the kitchen required works to ensure that it could be effectively cleaned.

The centre was very clean and tidy. The person in charge had in place systems for regular and deep cleaning of the centre. The centre was also homely, well-furnished and welcoming.

The inspector saw that there were adequate fire detection and prevention measures in place. However, due to the non-compliance of one resident with fire evacuations, there was a known risk that not all residents may be able to be evacuated in the event of a fire. This required review by the provider to ensure compliance with the associated regulation.

Residents' files were reviewed by the inspector. They were found to contain up-to-date assessments of need which were written in a person-centred manner and informed comprehensive care plans. Residents who required them also had recently reviewed positive behaviour support plans on their files.

There were a number of restrictive practices in place in the centre. Many of these were required due to the assessed needs of one resident and had been in place in the centre for several years. The person in charge had implemented strategies to minimise the impact of these restrictive practices on other residents. However, there was an absence of recorded consultation with other residents regarding these restrictive practices and the impact that they may be having on their rights to freely access all parts of their home.

Similarly, when reviewing medication records, the inspector saw that there was an absence of a capacity assessment to self-administer medications. The inspector was told that this had been previously completed with residents on admission however that documentation had not been maintained or reviewed subsequently. The inspector was told that some residents had asked staff to manage their medications

however this was not recorded and it was not clear what steps were in place to support those residents who could manage medications to maintain their autonomy in this regard.

The inspector was told by residents and staff that the residents in this centre were supported to develop and maintain positive links in their community and with their families. Residents accessed the community for lunches, coffee and for activities such as the gym and art classes. Many residents also travelled independently to day services, activities and to visit their families. Staff support was provided to those residents who required it in order to access the community to achieve their goals and wishes. Residents goals were seen to be meaningful and person-centred.

There had been a noted reduction in safeguarding incidents in this centre in the past 12 months. Staff reported that this was due to the increased one to one support provided to residents in the evenings. Staff were knowledgeable regarding their safeguarding roles and responsibilities.

Overall, the inspector found that residents were in receipt of person-centred care and support and were well-connected with their local community.

Regulation 13: General welfare and development

Residents in this house were in receipt of care and support in line with their assessed needs and expressed preferences. Residents' preferences were supported in relation to their daily activities. Some residents attended day services and were supported to maintain their autonomy in travelling independently to those services.

Other residents were supported to engage in community activities from their home in line with their assessed needs or individual preferences. For example, some residents had chosen to retire or semi-retire from day service and instead chose to relax in their home and access the community over the course of the day. Staff support was available to residents to access the community if they required it.

Residents and staff spoke about the positive links that residents have been supported to maintain with their families and to develop with the community. One resident was well known in her local coffee shop and enjoyed going there daily for coffee and to chat to the staff. Another resident described attending community based art classes. Other residents had been supported to join their local gym and sports clubs. This was reported to have a positive impact on residents' health and wellbeing.

Judgment: Compliant

Regulation 17: Premises

The designated centre was seen to be very clean, welcoming and generally well-maintained. Furniture and fittings were clean. There was ample availability of storage. The house had adequate communal facilities along with individual bedrooms for privacy.

Residents in this house had access to their own bedrooms, two sitting rooms, a large kitchen and dining area and three bathrooms. However the showers in two of these bathrooms were inaccessible to most of the residents. This meant that most of the residents relied on the use of only one bathroom for showers and washing. Works were required to ensure that the bathrooms were fully accessible to the residents.

The kitchen required minor works which were known to the provider and were on a schedule of works to be completed this year. The inspector saw that the kitchen cabinets and the countertop were damaged which meant that they could not be effectively cleaned.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had ensured that there were adequate arrangements to detect, contain and extinguish fires in the designated centre. Fire drills were completed in line with the provider's policy and residents' files contained up-to-date personal evacuation plans.

However, there was a known risk that one resident may refuse to evacuate in the event of the fire. The provider had explored several options to assist with the evacuation of this resident however these were deemed inappropriate or were ineffective. For example, an occupational therapy assessment had concluded that a particular evacuation chair would pose a risk to the resident if it were to be used. A ski sheet was supplied in the resident's bedroom however this required two staff to use it and only one staff was rostered on by night time. Furthermore, on the last night-time fire drill, the resident had left their bed and sat on the floor which rendered the ski sheet ineffective.

This risk was known to the provider and had been placed on the organisation's risk register as an orange rated risk. However the control measures did not demonstrate that all residents could be safely evacuated in the event of a fire in the designated centre. This required review by the provider to ensure that arrangements were in place to support the safe evacuation of residents in line with the requirements of the regulations.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There were suitable arrangements for the storage and administration of medications as well as for the disposal of out-of-date medications. A record of all medications administered was maintained. The inspector reviewed these records and saw that medications were administered as prescribed.

Most of the residents in the house relied on staff to support them with administering medications. The inspector was informed that a capacity assessment had been completed on admission of residents to the centre. However, this capacity assessment had not been reviewed and updated in line with the provider's policy on administration of medications. A review was required to ensure that supports were in place to assist residents to take responsibility for their medications if this was their choice.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A sample of residents' files were reviewed by the inspector. They were found to contain comprehensive assessments of need which had been updated within the last 12 months. The assessments of need were informed by the resident, their family, multi-discplinary team and keyworker as appropriate.

The assessment of need was used to inform comprehensively detailed care plans. These care plans were written in a person-centred manner and detailed the supports required to maintain residents' dignity and autonomy. Care plans were reviewed and updated regularly to reflect changes to residents' needs.

Judgment: Compliant

Regulation 6: Health care

Residents in this centre had access to a variety of healthcare professionals as required by their assessed needs. A record of healthcare appointments were maintained which showed that residents accessed healthcare support from the provider's own clinical team as well as primary and acute community based services if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices in place in this designated centre. Most of the restrictive practices had been identified by the person in charge and were reviewed and approved by the provider's monitoring committee. The inspector saw that there was one restrictive practice, a keypad by the front door, that had not been identified as such.

The restrictive practices were supported by comprehensive risk assessments and by the residents' positive behaviour support plans. Behaviour support plans had been recently updated and contained proactive and reactive strategies to support residents in managing their emotional well being and behaviour. Staff were knowledgeable regarding behaviour support plans and were seen to implement the proactive strategies as recommended.

A number of the restrictive practices were required due to the assessed needs of one resident. While the person in charge had implemented strategies to minimise the impact of the restrictions, for example, by providing residents with keys to locked cupboards, it was not found that residents had been consulted with regarding the restrictive practices or that their consent had been gained for them. This required review by the provider to ensure that residents' rights were fully upheld.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had enhanced the individualised supports available to residents in the evenings. This, along with a current vacancy and associated reduction in the number of residents living in the centre, were felt by staff to contribute to a reduction in the number of peer to peer related safeguarding incidents.

The inspector saw that, where safeguarding incidents occurred, these were responded to and investigated in line with the statutory requirements. Safeguarding plans were implemented to ensure that residents were protected from abuse.

Staff spoken with were knowledgeable regarding their safeguarding roles and responsibilities.

Residents' files contained intimate care plans. These were up-to-date, person-centred and provided information on how to maintain residents' dignity and autonomy when providing support with intimate care.

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	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for 36 Elmwood Park OSV-0002392

Inspection ID: MON-0041645

Date of inspection: 04/10/2023

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: In response to Substantial Compliance under Regulation 16 (1) (a): • the PIC has a plan in place on behalf of the Regular Relief Staff Member to complete their training in IPC, Fire Safety + Safeguarding • the staff member has begun the training and will be completed by end Nov 23	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: In response to Substantial Compliance under Regulation 4 (3): • the Provider provided a printed version of up-to-date Policies and Procedures to the Designated Centre • The Quality Dept are currently updating 2 Policies (Admissions Policy + Communication Policy) and will make them available when complete	
Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: In response to Substantial Compliance under Regulation 17 (4) + 17 (6): • The Provider has listed the minor works required in the kitchen for completion by year end • The Provider will arrange to review the 2 bathrooms upstairs with a view to making them more accessible for Residents by year end • Following a review of the upstairs bathrooms, if renovations are possible, the Provider will discuss any recommendations and funding with the Director of Estates to be included in the programme of works in 2024.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: In response to Substantial Compliance under Regulation 28 (3) (d): • The non-cooperation of one Resident with fire evacuation is known to the Provider • A Risk Assessment has been updated on 10/11/23 and is in place identifying the issue and control measures to address the concern. This Risk Assessment involved all stakeholders and was escalated to Senior Management. • All staff members have completed Fire Training which includes Simulated Role Play Training outlining what staff should do if the Resident will not evacuate • All internal doors in the house have had service/maintenance completed in October 23 to further ensure the FD30s in place operate as needed. This will further protect fire spread and thus Residents' safety if not evacuated • As per the Providers internal policy there are 2 formal fire drills carried out per year with additional fire walks to assist Residents in understanding what needs to happen in the event of a fire • There is an addressable Fire Alarm System in the house • Staff members are present 24 hours per day to implement fire procedures. The first step is to contact the Fire Brigade which is included as part of the Simulated Role Play Training • At local level the Resident has a detailed Individual Evacuation Plan (IEP). In it every effort is made by staff to support the person, in the event of a fire emergency, to cooperate with evacuation. The IEP includes known motivators to encourage the Resident to cooperate • The IEP provides that in the event of the Resident not cooperating with night-time evacuation of the house during a fire emergency, staff will open the bedroom window and close the bedroom door. Opening the window will allow staff to verbally reassure and supervise the Resident, from outside. Emergency Services will be informed of the Residents whereabouts on arrival • The Resident has been compliant with day-time fire drills and has a bedroom on the	

ground floor
• A further Individual Coordination Meeting was held on 6/10/23, with the Fire Officer and Psychologist present, to discuss the issues and review the measures in place
• The Service Manager discussed the issue further with the Director of Adult Services on 18/10/23 and 14/11/23 and again with the Fire Officer on 10/11/23. The Director of Adult Services also discussed the control measures with the Fire Officer on 15/11/23
• A second staff member present at night-time was considered but was deemed not to be reasonably practicable for the sole purpose of supporting an evacuation when all control measures in place were considered
• The Provider will review the fire procedure for the centre in the next 6 months and advise the Regulator of any changes required. This review will be completed by 15/5/24 with the Fire Officer and Senior Management of the centre
• The PIC will carry out an additional fire drill within the next 3 months. This will be completed by 20/2/24

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
In response to Substantial Compliance under Regulation 29 (5):

• The PIC will arrange to review and update the Resident's capacity assessment in relation to self-medication
• A suitable Support Plan will be drawn up following this assessment

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In response to Substantial Compliance under Regulation 7 (3):

• The PIC, in conjunction with the Psychologist, will arrange consultation with Residents in relation to restrictive practices and will make a record of this

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	30/11/2023
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise	Substantially Compliant	Yellow	31/12/2023

	disruption and inconvenience to residents.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/12/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	15/05/2024
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with	Substantially Compliant	Yellow	30/11/2023

	his or her wishes and preferences and in line with his or her age and the nature of his or her disability.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	31/12/2023
Regulation 07(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.	Substantially Compliant	Yellow	30/11/2023