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:	Cara Residential Service
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Unannounced
Date of inspection:	02 March 2022
Centre ID:	OSV-0003733
Fieldwork ID:	MON-0031285

About the designated centre

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

The designated centre forms part of a campus based service for persons with intellectual disabilities and is located in west Dublin. The centre is comprised of three individual bungalows and provides full time residential services to up to 14 adults. The layout of all three houses is very similar with a spacious entrance hallway, an open plan living and dining area with kitchen space, resident bedrooms, main bathroom and smaller toilet areas. Residents are supported 24 hours a day, seven days a week by a person in charge and a staff team of nurses, carers and house hold staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 2 March 2022	09:30hrs to 16:30hrs	Sarah Cronin	Lead
Wednesday 2 March 2022	09:30hrs to 16:30hrs	Marie Byrne	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place to monitor compliance with the regulations. The centre comprises three bungalows on a campus in west Dublin. While the centre is registered to accommodate fourteen residents, there were twelve residents on the day of the inspection. Each house has a similar layout with a large entrance area, a sitting room with a dining area and kitchen and four to five bedrooms in each house. One of the houses provides a service to residents with autism while the other two houses provide a service to residents with complex health care needs.

On the whole, residents were well presented and appeared content and comfortable in their homes. Staff who spoke with inspectors were found to be knowledgeable in relation to residents' care and support needs, and motivated to ensure they were happy and safe in their homes. Interactions were noted to be kind and caring between staff and residents. However, the inspection had poor findings in relation to a number of areas such as governance and management, staffing, staff training and risk management. These findings are outlined in the body of the report.

The inspectors visited two of the houses on the day of the inspection. It was not possible to enter the third house due to a positive case of COVID-19. The inspectors had the opportunity to briefly engage with five of the residents living in the houses. In one of the houses an inspector met with a resident who was sitting in their bedroom watching a slide show of pictures of themselves on their television. They were pointing to pictures and smiling and laughing. The staff member with her was narrating some of the pictures and commenting about what was happening in the pictures. The resident's room was personalised to their life history and their personal belongings were on display. The resident was offered a cup of tea and went to the dining table where they showed the inspector their puzzle. The inspector observed another resident get up from bed and go up to the kitchen. They returned to their room a short time later. The third resident was asleep at the time of the visit and the fourth resident was having their personal care needs attended to.

In the second house an inspector had the opportunity to meet and briefly engage with three of the four residents. One resident was resting in their bed while the inspector visited their home. Two residents were in the living room watching television after having their breakfast. They appeared relaxed and content, and there were magazines and arts and crafts materials available to them. One resident was relaxing in their bedroom when the inspector visited and they came up to the living area to greet the inspector. They chatted to a staff member about their plans to go to a local shopping centre to buy a gift for a friend. They then showed the inspector their bedroom before going to the living room to watch television. Staff spoke about the impact of restrictions relating to public health measure for residents in the centre. They discussed the positive impact for residents when visiting restrictions were lifted. For example, one resident had recently celebrated their

birthday and their family had visited and celebrated it with them.

Inspectors found the centre was not resourced appropriately to ensure that residents' care needs were attended to at all times. Inspectors viewed correspondence from management to staff stating that staff were required to attend to personal care needs prior to going off shift until another staff member was available two hours later. This meant that residents who had higher support needs were negatively impacted by a lack of staff resources.

Residents in this centre had tablets and used these to watch videos and keep in touch with family, in particular over the course of the pandemic. Residents were mostly engaging in home based activities in the centre. There was a dedicated day service staff for the three houses to support residents to engage in activities. Residents could access some activities such as bingo, or music sessions weekly if they wished. However, inspectors found that residents in the centre had limited opportunities to engage in activities outside of the centre. For example, there was no evidence to demonstrate that some residents had left their home over a four week period. For some residents they had left their home to go for a small number of walks around the campus, and for other residents there was no documentary evidence to show they had left the campus during the four week period. Inspectors also found that residents' social goals were limited. For example, one resident had two goals in place, both of which related to home based activities.

Inspectors viewed two compliments from residents' representatives where they expressed their appreciation for care and support offered to their relative in the centre. From what the residents and staff told us, a review of documentation and from observations, it was evident that residents were content and comfortable in their homes. Findings from this inspection demonstrated poor levels of compliance with the regulations, some of which had a negative impact on the lived experience of the residents. The next two sections of this report present the inspection findings in relation to the governance and management of the centre and how governance and management arrangements affected the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that the governance and management systems in place were not adequate to oversee and monitor the services provided to residents to ensure that they were receiving safe, good quality care. Due to concerns relating to the oversight and monitoring of care and support and the heightened risk for residents associated with this, a meeting was scheduled with the provider after the inspection.

The provider had completed an annual review in line with the regulations for 2020. Inspectors were informed that the annual review for 2021 was in the process of being completed. Six monthly audits were not available to view on the day of the inspection. A six monthly audit was sent to the inspector after the inspection took

place. This had been completed in January 2022. However, there was no evidence of six monthly audits carried out in 2021. Some audits were taking place locally such as health and safety, medication audits and household audits. However, it was unclear what actions were required and whether they had been actioned. Staff meetings were due to take place monthly and there was a suggested agenda in place from the provider. However, records indicated that these were not always taking place on a monthly basis and the minutes of meetings were not in line with the standing agenda. For example, incidents and complaints were not routinely discussed. There had been a new person in charge appointed since the last inspection in June 2021. The person in charge worked on a full- time basis and was in a supernumerary post. They demonstrated good knowledge of the residents and their needs.

As with previous inspections of the centre, inspectors found that the centre continued to be under resourced. There were a significant number of staff vacancies on the day of the inspection. A review of planned and actual rosters indicated that while shifts were filled in line with staffing levels identified by the provider, the centre remained under resourced. On one of the rosters, not all staff who had covered shifts were named. Inspectors found that staff ratios were not adequate to meet residents' assessed needs at certain times of the day, particularly in relation to personal care. For example, correspondence between management and staff was viewed requesting that staff attend to personal care needs of residents be attended to prior to going off their shift until another member was available to assist residents requiring the support of more than one staff two hours later. The inspector noted that the provider had submitted two notifications involving accidental minor injuries to residents in the months prior to inspection. Both of these incidents had occured during personal care routines. It was further noted that some of the residents' intimate care plans had information pertaining to another resident on it and did not therefore give clear guidance to staff on how best to support these residents. Risk assessments had not been updated following a minor injury. Staff meeting minutes documented staff requesting an increase in staffing numbers due to increased workloads. A review of staff files which took place prior to the inspection indicated that there were some gaps in the documentation required by the regulations.

A review of staff training records indicated that while all staff had completed training in fire safety and manual handling, a number of gaps were identified. For example 75% of staff required a refresher in food safety or an initial course. Only 50% of staff had completed training in supporting people with feeding , eating, drinking and swallowing which was an identified care need of some residents. One of the houses in this centre is a service for residents with autism. However, the majority of staff had not completed any training in supporting people with autism or in managing behaviours of concern. Choking was an identified risk but not all staff had first aid training to respond in the event of an emergency. For new staff who had joined the organisation, probation reviews were taking place up to six months after their start date. The provider had identified the need for staff supervision. While there were plans and a schedule in place on the day of the inspection, this had not yet commenced.

Inspectors found that there was duplication of information and inconsistencies

across a large number of documents reviewed. Some documents were not fully completed, and for other documents reviewed it was not evident who developed them, when they were created, or when they were last reviewed. For example, there were three documents in residents' plans relating to fire evacuation, and the language used in these was not consistent, nor was the information contained in them. Other examples related to residents' feeding, eating and drinking assessments and plans, residents' risk assessments, and residents' intimate care plans. Some documents reviewed were not found to be accurate or up-to-date. For example, the wrong residents' names were contained in some residents' documents, and some documents contained the name of a different designated centre. This meant that there was not clear guidance available to staff for many aspects of residents' care. A review of incidents indicated that the office of the Chief Inspector had been notified of incidents as required by the regulations.

There was a complaints policy and a user-friendly version was available for residents. From reviewing a sample of residents' meetings the complaints process was being regularly discussed. There was a small number of complaints raised by residents in 2020 and 2021, and none recorded for 2022. There was a complaints and compliments log in place; however, there was limited evidence of oversight of this process in the centre. Complaints was not a standing agenda item on staff meetings in the centre. The provider's complaints policy had recently been reviewed; however the latest version was not in the complaints folder for the centre, and there were forms and templates in the centre which were not included in the recently reviewed policy.

Regulation 15: Staffing

Inspectors found the centre to be under resourced to meet the assessed needs of residents at all times. There were a significant number of staff vacancies on the day of the inspection. A review of planned and actual rosters indicated that while shifts were filled in line with staffing levels identified by the provider, the centre remained under resourced. Staff ratios were not adequate to meet residents' assessed needs at certain times of the day, particularly in relation to personal care. This meant that some residents were experiencing delays in having their personal care needs attended to due to inadequate staffing levels. This issue had been highlighted by staff at a recent staff meeting but it was unclear what actions had been taken. A review of staff files which took place prior to the inspection indicated that there were some gaps in the documentation required by the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of staff training records indicated that while all staff had completed training in fire safety and manual handling, a number of gaps were identified. For example 75% of staff required a refresher in food safety or an initial course. Only 50% of staff had completed training in supporting people with feeding , eating, drinking and swallowing which was an identified care need of some residents. One of the houses in this centre is a service for residents with autism. However, the majority of staff had not completed any training in supporting people with autism or in managing behaviours of concern. Choking was an identified risk but not all staff had first aid training to respond in the event of an emergency. For new staff who had joined the organisation, probation reviews were taking place up to six months after their start date. The provider had identified the need for staff supervision. While there were plans and a schedule in place on the day of the inspection, this had not yet commenced.

Judgment: Not compliant

Regulation 21: Records

During the inspection inspectors found that there was duplication of information and inconsistencies were found across a number of documents reviewed. Some documents were not fully completed, and for other documents reviewed it was not evident who developed them, when they were created, or when they were last reviewed. For example, there were three documents in residents' plans relating to fire evacuation, and the language used in these was not consistent, nor was the information contained in them. Other examples related to residents' feeding, eating and drinking assessments and plans, residents' risk assessments, and residents' intimate care plans. Some documents reviewed were not found to be accurate or up-to-date. For example, the wrong residents names were contained in some residents' documents, and some documents contained the name of a different designated centre. This meant that there was not clear guidance available to staff for many aspects of residents' care.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that the governance and management systems in place were not adequate to oversee and monitor the services provided to residents to ensure that they were receiving safe, good quality care. The provider had completed an annual review in line with the regulations for 2020. Inspectors were informed that the annual review for 2021 was in the process of being completed. Six monthly audits were not available to view on the day of the inspection. A six monthly audit was sent to the inspector after the inspection took place. This had been completed in

January 2022. However, there was no evidence of six monthly audits carried out in 2021. Audits did not appear to be actioned or lead to service improvements

Judgment: Not compliant

Regulation 31: Notification of incidents

A review of incidents indicated that the office of the Chief Inspector had been notified of incidents as required by the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy and a user-friendly version was available for residents. From reviewing a sample of residents' meetings the complaints process was being regularly discussed. There was a small number of complaints raised by residents in 2020 and 2021, and none recorded for 2022. There was a complaints and compliments log in place; however, there was limited evidence of oversight of this process in the centre. Complaints was not a standing agenda item on staff meetings in the centre. The provider's complaints policy had recently reviewed; however the latest version was not in the complaints folder for the centre, and there were forms and templates in the centre which were not included in the recently reviewed policy.

Judgment: Substantially compliant

Quality and safety

As stated earlier in the report, the inspectors found that while residents appeared comfortable and content, a number of improvements were required to ensure that residents were receiving support that was safe and good quality. A sample of personal plans indicated that residents' had an assessment of need carried out annually and corresponding care plans were developed. The plans were detailed and found to be reflective of residents' care and support needs and their will and preferences. As previously stated, improvements were required in ensuring that all information in residents' files remained up to date. Residents were being supported to enjoy best possible health. They had their health care needs assessed and support plans were developed and reviewed as required. Residents had access to

health and social care professionals such as speech and language therapy, occupational therapy and physiotherapy. Recommendations from these professionals were used to inform care plans.

A number of residents had risk assessments and guidelines in place in relation to their behaviour support needs. At the time of the inspection, the provider was in the process of implementing new positive behaviour support documentation. The guidance available to staff on the day of the inspection was not found to have enough detail to clearly guide staff practice in supporting residents. Risk assessments reviewed were not dated or fully completed. Documentation in place had general information which was not detailed in relation to the specific positive behaviour support strategies required proactively identify and respond to residents' behaviour during times of stress, or anxiety. Staff training records indicated that very few members of the staff team had completed training to support residents with proactive and reactive strategies, including physical interventions which may be required. There were a number of restrictive practices in the centre and these were being reviewed regularly to ensure they were the least restrictive for the shortest duration. For example, there had been a reduction in restrictions for one resident since the last inspection. Restrictions were also reviewed in relation to their impact of each resident living in the house. However, inspectors found one restriction relating to a locked external door in one house which had not been recognised, recorded or reported as a restrictive practice.

From a review of a sample of residents' financial records and activity records, there was limited evidence that residents were supported to engage in activities outside their home. For some residents it was not evident they had left their home or the campus for extended periods. For example, there was no evidence to demonstrate that some residents had left their home over a four week period. For some residents they had left their home to go for a small number of walks around the campus, and for some residents there was no documentary evidence to show they had left the campus during the four week period. Inspectors also found that residents' social goals were limited. For example, one resident had two goals in place, both of which related to home based activities.

Inspectors found the two houses visited to be in a good state of repair. They were warm and well ventilated. Each premises visited was found to be clean and residents had ample space for their belongings. Houses were physically accessible and there were ceiling and freestanding hoists in use.

Inspectors found that the risk management systems were not effective in ensuring oversight of identified risks in the centre. Each house had a safety statement, a risk register and an incident and accident log. Inspectors were informed that the risk registers were in the process of being updated. While there were risk assessments in place relating to different aspects of residents care, many of them required updates. In particular, assessments were not updated following incidents which had resulted in injuries to residents. Some risk assessments were incomplete and missing dates. It was unclear to inspectors whether learning from events was occurring, as this did not appear to be discussed on the staff meeting minutes which were viewed. It was not evident that learning from adverse events was taking place and shared with the

staff team.

Residents, staff and visitors were protected by the infection prevention and control policies, procedures and practices in the centre. The provider had developed contingency plans for use during the COVID-19 pandemic. There was information available and on display for residents and staff in relation to standard precautions and COVID-19. There was stocks of PPE available in the houses and systems for stock control. Staff had completed a number of infection prevention and control related trainings. The premises were found to be clean during the inspection and there was documentary evidence to show that each area of the houses were cleaned regularly.

In the two houses viewed, the inspectors found that there were fire containment and detection systems in place. Emergency lighting was fitted and in good working order in addition to fire-fighting equipment being available to staff. Documentation reviewed indicated that these were serviced and checked regularly. Each resident had a personal emergency evacuation plan.

Regulation 13: General welfare and development

From a review of a sample residents' of residents' financial records and activity records, there was limited evidence that residents were supported to engage in activities outside their home. For some residents, the evidence indicated that they had left their home or the campus for extended periods. For example, there was no evidence to demonstrate that some residents had left their home over a four week period. For some residents they had left their home to go for a small number of walks around the campus, and for some residents there was no documentary evidence to show they had left the campus during the four week period. Inspectors also found that residents' social goals were limited. For example, one resident had two goals in place, both of which related to home based activities.

Judgment: Not compliant

Regulation 17: Premises

Inspectors found the two houses visited to be in a good state of repair. They were warm and well ventilated. Each premises visited was found to be clean and residents had ample space for their belongings. Houses were physically accessible and there were ceiling and freestanding hoists in use.

Judgment: Compliant

Regulation 26: Risk management procedures

Inspectors found that the risk management systems were not effective in ensuring oversight of identified risks in the centre. Each house had a safety statement, a risk register and an incident and accident log. Inspectors were informed that the risk registers were in the process of being updated. There did not appear to be a system of oversight in place to monitor all of the risk registers in the centre and ensure they remained up to date and reflective of residents' needs. While there were risk assessments in place relating to different aspects of residents care, many of them required updates. In particular, assessments were not updated following incidents of concern. Some risk assessments were incomplete and missing dates. It was unclear to inspectors whether learning from events was occurring, as this did not appear to be discussed on the staff meeting minutes which were viewed.

Judgment: Not compliant

Regulation 27: Protection against infection

Residents, staff and visitors were protected by the infection prevention and control policies, procedures and practices in the centre. The provider had developed contingency plans for use during the COVID-19 pandemic. There was information available and on display for residents and staff in relation to standard precautions and COVID-19. There was stocks of PPE available in the houses and systems for stock control. Staff had completed a number of infection prevention and control related trainings. The premises were found to be clean during the inspection and there was documentary evidence to show that each area of the houses were cleaned regularly.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A review of a sample of personal plans indicated that residents' had an assessment of need carried out annually and corresponding care plans were developed. The plans were detailed and found to be reflective of residents' care and support needs and their will and preferences.

Judgment: Compliant

Regulation 6: Health care

Residents were being supported to enjoy best possible health. They had their health care needs assessed and support plans were developed and reviewed as required. Short term care plans were also developed where they were required. Residents had access to health and social care professionals such as speech and language therapy, occupational therapy and physiotherapy. Recommendations from these professionals were used to inform care plans.

Judgment: Compliant

Regulation 7: Positive behavioural support

A number of residents had risk assessments and guidelines in place in relation to their behaviour support needs.These risk assessments were found to be incomplete and it was unclear what date they had been done. Documentation in place had general information which was not detailed in relation to the positive behaviour support strategies to proactively identify and respond to residents' behaviour during times of stress, or anxiety. Staff training records indicated that very few members of the staff team had completed training to support residents with proactive and reactive strategies, including physical interventions which may be required. There were a number of restrictive practices in the centre and these were being reviewed regularly to ensure they were the least restrictive for the shortest duration. For example, there had been a reduction in restrictions for one resident since the last inspection. Restrictions were also reviewed in relation to their impact of each resident living in the house. However, inspectors found one restriction relating to a locked external door in one house which had not been recognised, recorded or reported as a restrictive practice.

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	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Cara Residential Service OSV-0003733

Inspection ID: MON-0031285

Date of inspection: 02/03/2022

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Each resident will be supported to have an Individual Needs and Preference Assessment (IPNA) completed to determine their needs and preference and supports required to support then to lead their best quality of life. The Centre will have an Assessment of Needs and SIS completed for individuals to determine appropriate resources required for individual support needs. Business case to be completed where staff gap analysis identified. Staff recruitment for current vacancies continues via HR Department. One Staff Nurse has commenced since the findings of the report. HR have engaged with Recruitment agencies to assist with staff recruitment and RNID Graduate Recruitment Day held on site on 22nd March. Regular agency staff currently supporting the Centre during staff vacancies. HR files will be reviewed and all gaps identified in documentation will comply with Regulations. All rosters will include names of all staff who cover daily shifts.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training Analysis has been completed for the Centre. All training gaps for staff have been identified. Department of Education has been furnished with training need requirement for the Centre to include:-

- Food safety
- FED's Assessment
- Autism
- Positive Behaviour Support
- First Aid

Training will be co-ordinated by the PPIM and PIC and training schedule implemented.

Probation Reviews

Schedule currently implemented to ensure all probations for staff are implemented in line with policy.

Staff Supervision

PIC has completed schedule for staff supervision for 2022. Same has commenced within the Centre, PPIM will provide governance re implementation

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
A systematic review of personal plans has been devised whereby assigned staff / keyworkers will complete same.

All records including residents documents in the Centre have been scheduled for a review to ensure same are accurate, up to date and completed correctly.

There will be an Annual MDT for each person in the Centre and any recommendations or change identified will be incorporated into the Individual Personal Plan. Audit schedule implemented in the Centre to ensure records are accurate and reflective of current practice.

Records

All records on site are to be reviewed to ensure all documents are accurate and up to date. PIC has implemented schedule of review.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Annual review for the Centre will be completed and actions will be implemented in line with Regulation.

Six monthly Audits will be completed in line with Regulation to ensure residents are in receipt of safe and good quality care.

Audit schedule has been identified for the Centre. Evidence of Action Plan implementation and evaluation will be available in the Centre.
Audit findings, actions and evaluation will be shared at local residents and staff meetings and identify service improvements required and achieved.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Latest version of Complaints Policy has been placed in complaints folder.

The PIC will implement a three monthly audit of all complaints within the Centre to ensure evidence of oversight in the Centre. PPIM will review complaints on a monthly basis with PIC.

Complaints will be a standing agenda on residents and staff meetings to ensure complaints are discussed and identified shared learning outcomes are achieved.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Review of staffing will identify supports required to ensure quality of life for residents is

enhanced and reflects individuals wish and preference.

Weekly consultation with residents will assist with planning of activities outside the home. New weekly activity planner has commenced.

Monthly keyworker meetings will be held with each resident to explore meaningful activities in the community and evidence will be documented in Quality of Life section in individual Care Plan.

PPIM and PIC will evaluate and audit individual community participation monthly and implement action plans accordingly.

Social goals for all residents is being reviewed and will reflect individual will and preference for social engagement in the individual Care Plan or PCP.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All risk assessments in the Centre are being reviewed and will be completed accurately and will reflect the current risk status of all residents.

Individual Risk Assessments will be placed in relevant section of persons Care Plan.
A summary of all risk assessments will be held in the centre Risk Register.

Risk Management training workshop was provided by Quality and Risk Officer to PIC on 8th March

Risk Management workshops will be scheduled for staff in the Centre.

PIC has incorporated Risk Management into local safety pause.
Risk Management has been placed on staff meeting agenda and learning outcomes will be identified.

Following any incident, relevant risk assessments for residence will be updated to reflect any change to control measures or risk rating.

Audit of incidents/Accidents will be conducted three monthly within the Centre and information shared at local staff meetings. Learning form incidents will also be shared at daily safety pause.

PPIM will meet with PIC monthly and review Risk Management procedures.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Risk assessments and guidelines supporting Residents needs are being completed to reflect strategies to support resident's during times of stress or anxiety.

CNS in Positive Behaviour Support to complete training with all staff in Positive Behaviour Support and Autism.

Restrictive Practices relating to locked external door has been reviewed at Restrictive Practice meeting 29.03.2022 and will be reported in line with Regulations.

Restrictive Practices will be discussed at Staff Meetings and Restrictive Practices log updated.

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 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/08/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Not Compliant	Orange	31/08/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the	Not Compliant	Orange	30/09/2022

	number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	30/09/2022
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	30/09/2022
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.	Not Compliant	Orange	30/09/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation	Not Compliant	Orange	30/06/2022

	to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Red	31/05/2022
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	Red	31/05/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on	Not Compliant	Orange	30/07/2022

	the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	30/07/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	01/06/2022
Regulation 34(1)(a)	The registered provider shall provide an effective complaints procedure for residents which is	Substantially Compliant	Yellow	01/07/2022

	in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure that the procedure is appropriate to the needs of residents in line with each resident's age and the nature of his or her disability.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/06/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/06/2022
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before	Substantially Compliant	Yellow	30/06/2022

	a restrictive procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/06/2022