



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

Issued by the Chief Inspector

Name of designated centre:	Dunwiley & Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	02 September 2021
Centre ID:	OSV-0005489
Fieldwork ID:	MON-0032540

About the designated centre

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

The centre is located within a small campus setting which contains three other designated centres operated by the provider. Dunwiley and Cloghan provides full-time residential care and support to eight male and female adults. The designated centre comprises of a six bed bungalow and a four- bed bungalow. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. There are two buses available for residents to access the community if they wish. Residents are supported by a staff team of both nurses and care assistants. During the day, support is provided by seven staff (five in one house and two in the other house). At night residents are supported by two staff members in each bungalow. Nursing care is provided on a 24/7, basis meaning a nurse is allocated in each bungalow during the day and at night. The person in charge is responsible for one designated centre and is supported by a clinic nurse manager 1to ensure effective oversight of the services being provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 2 September 2021	11:00 am to 7:30 pm	Thelma O'Neill	Lead
Thursday 2 September 2021	11:00 am to 7:30 pm	Angela McCormack	Support

What residents told us and what inspectors observed

This inspection was a follow-up to a monitoring inspection conducted in March, which had found considerable risks and poor quality of care to residents. There were eight residents living in this centre, five in Dunwiley and three in Cloghan. There were two vacancies, that were not being filled as part of a regulatory plan for this centre. Inspectors met with residents and staff in both houses and had the opportunity to observe some of the interactions between residents and staff in the centre.

On arrival to Cloghan, inspectors met with one resident and the staff supporting them. Two residents were gone out on a community outing with another staff on the centre's transport. The resident who inspectors met with in the morning appeared happy, smiling and interacting with staff in a jovial manner and staff were observed to respond to them in a caring and respectful way. The resident agreed to show inspectors their individual sitting-room. This was observed to be nicely decorated and was described as the area that the resident enjoyed watching television programmes of choice and listening to music. Inspectors observed that the resident's independent advocate was visiting that day, and later observed the behaviour specialist also visiting the centre.

Staff spoken with talked about the resident's plans for the day, and showed the inspector the visual schedule that was available to the resident to support them in making choices about their day. The inspector was informed that the resident often chose to remain at home, and staff spoke about how they were supporting the resident to make choices and engage more in community outings. During the day of inspection, the resident was supported to go out for a walk in line with their choices. The inspector met with two other residents on their return from their outing later in the afternoon. Residents spoke with the inspector on their own terms, and were observed to be supported by staff. One resident spoke about their outing and also about their garden and the flowers that they planted. Residents appeared comfortable with staff, and in their environment.

Cloghan appeared clean, homely and spacious for the three residents who lived there. There were easy-to-read documents and visual rotas in place around the home. There was a garden area which was nicely decorated with garden furniture and potted shrubs and flowers. Inspectors were told that some residents liked to take part in gardening tasks such as watering the flowers, and one resident spoke about this later in the day

On arrival at Dunwiley, the inspector met one resident and the staff member supporting them. They said that they were happy living in the house, and that staff were good to them, but were upset that their mobile phone had been taken off them and wanted the inspector to tell the person in charge to return the phone. The person in charge told the inspector that there was a restriction in place around this person's access to a mobile phone, and that a behaviour support plan was in place

regarding the use of the phone and that this restriction was being reviewed that afternoon by the multidisciplinary team.

Later in the afternoon, the resident became more anxious and was verbally aggressive towards others in the centre and left the campus against staff advice which was deemed a serious health and safety risk for the resident and others. Staff tried to encourage them to return to the centre; however, they became upset and allegedly assaulted staff who were encouraging them to return to the centre. Inspectors were informed of the situation unfolding during the inspection, and that the Gardai were advised of the incident and were requested to return the resident to centre. This resident was upset on their return and the General Practitioner (G.P.) was called to assess the resident's health and well-being and PRN medication was administered. This incident was upsetting for the other residents to observe and listen to during the day. A nurse told the inspector that this type of behaviour was a regular occurrence in the centre and that these types of incidents negatively impacted on the other residents, and the resident urgently needed to move to a more suitable service to ensure their safety, and improve the quality of life for the other residents.

Inspectors met with the other residents who lived in Dunwiley, and they appeared to be more settled than the previous visit to the centre in March. However, while inspectors were reviewing documentation in the office area, one resident came in and engaged with inspectors. They said that they had been out for a walk earlier in the day and when asked if they liked living at the centre, the resident said that they didn't. They became upset, visibly crying, and subsequently told inspectors that they did not feel safe living there, and that they did not have any friends there. They did not indicate or state what made them feel afraid in the centre, but clearly said that they would like to move to another house. The management team were made aware of this and agreed to follow up with the resident to support them in making choices about where they lived. Later in the day, the resident was observed to be sitting out on the campus at another location.

Through observations, reviews of documentation and discussions with staff, inspectors found that the number of incidents of behaviours of concern and safeguarding incidents at the centre which resulted in assaults to residents and staff continued to be a concern. Inspectors also spoke to four staff members working in the centre. Staff were complimentary of the additional multidisciplinary team (MDT) support received in the centre since the last inspection. They told inspectors that there was a psychologist, a behaviour support specialist and speech and language therapist recruited to work part-time in the campus, which were supporting some residents in the centre.

Since the last inspection, a new person in charge was appointed to manage the centre. They told the inspector of their commitment to support residents in managing behaviours of concern. One of key areas they had found to have helped reduce incidents was by identifying meaningful and individual goals for residents to achieve and to offer opportunities for individual activities and new experiences. The person in charge showed the inspector how they had developed an individualised social activities record and an activity satisfaction sheet for staff to record any

activities that residents enjoyed. This had helped to increase residents' willingness to participate in social activities and had reduced the number of incidents of concern recorded in the centre.

During discussions with the person in charge and staff, they told the inspectors that two buses were available at Dunwiley since the last inspection, and this had allowed staff to support residents to participate in separate social activities, and that residents that needed to travel on the bus separately for safety reasons now had the opportunity to do so and this no longer impacted on the other residents' social activities.

The accessibility of food in the centre had been reviewed since the last inspection, as previously inspectors had found there was a lack of access to food outside the opening hours of the centralised kitchen. On this occasion, food continued to be provided by the centralised kitchen on the campus, and dinner arrived at the centre at 12.30pm and evening tea at 4.30pm. However, the centre had adequate quantities of food and drinks to offer choices to residents outside of meal times, and one resident told the inspector that the staff cooked them pizza a few times in the evenings.

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

Capacity and capability

On the last inspection of this centre inspectors found that the provider did not demonstrate effective governance and management arrangements to ensure a good quality of care and support for residents. Consequently, a warning letter was issued to the provider. The provider was required to submit monthly quality improvement plan updates to the Health Information and Quality Authority (HIQA) to update on the status of actions, and provide assurances that appropriate measures were being put in place to ensure that the quality and safety of residents' care was improving in the centre.

Inspectors reviewed the risks identified in the centre on the last inspection and the actions the provider had taken to address these risks. In May 2021 a new person in charge was appointed to manage the day-to-day operational management of the centre. They were a qualified Intellectual Disability Nurse and Clinical Nurse Manager 2 who also had a qualification in applied behaviour analysis. A Clinical Nurse Manager 1 (CMN1) had also been recruited to work in the centre, however they were not yet in post as they were required as a nurse, due to staff nurse shortages in the campus. The person in charge was also supported by a staff team of nurses and health care assistants. In addition, a new Director of Services (DOS) was recently appointed to manage the Ard Greine Campus, of which this centre is

one of four designated centres on the campus.

Inspectors found that there were improvements in the governance and management structure of the centre, and in areas such as multidisciplinary supports, human resources, staff training, food and nutrition, as well as social activities at the centre. However, significant risks to the health and safety of residents remained an issue in Dunwiley and this situation will not change until identified actions relating to compatibility of residents are addressed.

Two residents that were scheduled to move from Dunwiley to two more suitable services by the 31/7/2021 had not been transitioned and the provider had now identified November as the date for these two residents to transition from the centre. This was a concern, as other residents living in the centre were considered to be at risk, and told inspectors that they did not feel safe and did not want to live in the centre.

The person in charge told the inspector that there was a consistent staff team working in the centre and that in Dunwiley each resident had a 1:1 staff support. Five staff work in centre daily and also a day support staff worked 9-5 daily during the week. There were also two staff working nights. In Cloghan there was two staff plus one daily activity staff and two staff working in the centre at night. These staffing arrangements had helped to manage and reduced the high risks occurring in the centre previously. However, incidents were continuing to occur, due to the incompatibility of residents in the centre.

While there appeared to be enough staff available to support residents with their needs on the day of inspection, inspectors were told there was a high absenteeism in the centre. The person in charge also told inspectors that the provider's commitment to to have a dedicated staff team and independent roster for Dunwiley and Cloghan by the 31/7/2021 were not yet in place. This was required to ensure continuity of care to residents and to ensure residents' care and support needs would be met.

The provider had applied to HIQA to reconfigure the designated centre to reduce the number of houses in this designated centre to one. A decision on this application to vary the registration of this centre was on hold by the regulator until all of the centres in the campus had a follow-up inspection completed and the outcome reviewed. The provider had also increased oversight by the senior management team by ensuring monthly, fortnightly and weekly meetings were held to implement and monitor quality and safety and regulatory compliance levels in the centre. These included quality and patient safety committee meetings, the development of a human rights committee and monthly oversight reviews by the national safeguarding team. Inspectors briefly met with representatives from the national advocacy service during the inspection, who had received a number of referrals to support residents living in the centre and they were meeting with residents on the day of inspection.

The provider had a list of mandatory training that was required for all staff and which detailed the refresher period. On review of the training matrix and training

records, inspectors found gaps which made it difficult to establish if staff had received all of the required training. This included gaps in safeguarding, management of behaviours and fire safety training for some staff. Later in the day, it was confirmed that staff had completed the safeguarding training, but that the fire safety training was still outstanding. It was unclear if all staff had completed the management of behaviours training, but the DOS confirmed at the feedback meeting this was due to be completed by all staff by the 2nd of September. In addition, a review of incidents noted that one resident had a near miss with regard to a choking incident, and it was found that not all staff had First Aid training to support the resident with this risk.

Regulation 14: Persons in charge

The person in charge had the qualifications, skills and experience to manage this centre. They started in their role in May 2021 and appeared knowledgeable about residents' individual needs. This person in charge was based in Dunwiley and available to provide support to residents and staff as required.

Judgment: Compliant

Regulation 15: Staffing

While there appeared to be enough staff available to support residents with their needs on the day of inspection, the dedicated roster for each unit had yet to be completed, This was required to ensure continuity of care to residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had a list of mandatory training that was required for all staff and which detailed the refresher period. On review of the training matrix and training records, inspectors found gaps which made it difficult to establish if staff had received all of the required training. This included fire safety training for some staff and some staff were out of date for positive behaviour support training, but were scheduled to complete on the 2/9/2021. In addition, a review of incidents noted that one resident had a near miss with regard to a choking incident, and it was found that not all staff had First Aid training to support with this risk.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was improvement in the governance and management structures and resources available in the centre, such as; multidisciplinary supports, human resource development and staff training at the centre. However, significant risks to the quality and safety of residents remained in Dunwiley and actions set by the provider to manage these significant risks were not achieved in line with their own quality improvement plan and assurances given to HIQA. This was a concern as residents and staff continued to be at risk in this centre, and one resident told inspectors they did not feel safe and did not want to live in the centre. Inspectors found that the management team had not identified this risk in the provider audits on the quality and safety of the service.

Judgment: Not compliant

Quality and safety

There was a good improvement in the quality and safety of care provided to residents in the centre since the last inspection. Staff and residents said they were more supported in the centre and had access to the multidisciplinary team and changes in the governance and management in the centre had led to improvements. However, there continued to be regular incidents of physical and psychological abuse occurring in the centre, but the frequency and intensity of incidents occurring had reduced.

Since the last inspection in March 2021, residents told inspectors they had access to the multidisciplinary team to help them manage behaviours of concern. There was evidence of ongoing reviews of behaviour support plans, and inspectors observed that a senior psychologist and a behaviour support specialist were available to support residents and staff and were involved with reviewing residents' behaviour support needs.

A review of chemical restraint administration in Cloghan showed a decrease in use since the last inspection, with care notes indicating that the diversional techniques as detailed in the support plans were used to good effect. However, in Dunwiley there continued to be a significant use of PRN medicines as an emergency management strategy for anxiety, or threats of, or incidents of violence or aggression in the centre.

There were strategies to support residents' enhancement of skills and engagement

in meaningful activities, and a visual schedule was observed for use to support a resident's communication and anxiety related to leaving the house for activities. Communication dictionaries were in place to guide staff on how best to support residents' with their communication preferences. Communication preferences were detailed in support plans and included a list of behaviours that individual residents engage in to communicate, and provided guidance to staff in how best to support residents with their needs.

A sample of resident files reviewed demonstrated that residents' annual review meetings had taken place recently. It was noted that residents chose not to attend, and where family members were invited, they had declined. The meetings involved multidisciplinary support staff and reviewed health, communication and social care needs. A daily activity chart was in place, which showed the choices residents made with regard to their day-to-day activities, and which aimed to support residents to engage in meaningful activities in line with their wishes and preferences. Some activities chosen included; coffee out in a nearby town, walks in the woods, gardening, watching movies, visiting the church and this document also noted where residents declined activities.

Staff received training in safeguarding. Incidents that occurred in the centre were kept under regular review by the management team. An action from the previous inspection included the need for residents to have an overarching safeguarding plan to detail all the safeguarding risks to them as identified. However, on review, inspectors found that the safeguarding plans for residents were not specific and did not detail all the safeguarding risks that were detailed on various documents, such as on individual residents' behaviour support plans. This created a risk that staff would not be aware of the risks identified for each individual and about what the specific control measures were. As previously discussed, one resident told inspectors they did not feel safe and did not wish to live in the centre. The person in charge told inspectors that they were not aware of the resident's safety concern and that they did not want to live in Dunwiley. This was despite, several preliminary screening been submitted for this resident following incidents of suspected psychological abuse in the centre.

Inspectors noted that residents had been referred for independent advocacy services, and observed meetings with their advocates taking place on the day of inspection. Staff spoken with talked about how the food choices had improved since the last inspection, and while main meals were still being delivered from a centralised kitchen, residents had a more varied choice and were offered two options every day. In addition, the kitchen cupboards and fridges were found to contain a variety of food which were available to residents in addition to their main meals from the main kitchen. Each individual had a treat box also, which stored their preferred treat options.

The provider had systems in place for the assessment, management and ongoing review of risk, which identified that there was a very high level of personal risks to both residents, staff and visitors. However, individual risk assessments did not correspond with the organisational risk assessment, despite the risks being present. The number of incidents recorded in the centre that impacted on residents had

significantly reduced, however, there continued to be a high number of incidents of threats or actual assaults towards staff. In addition, some known risks of aggression and violence were not risk assessed and appropriate control measures put in place to guide staff on how to manage the risks when they occurred. For example, one resident that was aggressive towards staff when they tried to prevent them from leaving the campus during the inspection, did not have a risk assessment in place or control measures documented, even though this risk was known to occur frequently. Inspectors also found that nursing assessments relating to one resident's behaviours towards other residents stated that a risk assessment was in place. However, it was unclear if this was completed or not as it was unavailable for review. This gap in documentation could impact on the management of the risks to ensure residents' safety.

Regulation 10: Communication

The inspector found the provider had put appropriate supports in place to facilitate the assessed needs of the residents, such as, assistive technology and aids and appliances. Furthermore, residents had access to a speech and language therapist to assess some residents communication needs.

Judgment: Compliant

Regulation 18: Food and nutrition

Staff spoken with talked about how the food choices had improved since the last inspection, and while main meals were still being delivered from a centralised kitchen, residents had a more varied choice and were offered two options every day. In addition, the kitchen cupboards and fridges were found to contain a variety of food which were available to residents in addition to their main meals from the main kitchen. Each individual had a treat box also, which stored their preferred treat options.

Judgment: Compliant

Regulation 26: Risk management procedures

Some residents' risks were not assessed or reviewed in their individual risks assessments or nursing intervention plans following incidents occurring in the centre. In addition, although the centre risk register had identified high risks of aggression and violence to others in the centre, the level of risk was not clearly identified in the resident's individual risk assessment. Inspectors also found there were gaps in documentation regarding risk assessments as it was unclear if they had been completed or not.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Infection control measures had been enhanced in response to the risk of COVID-19 and reflected current public health guidance. It also included the changes to the isolation unit available to residents in the campus, should the need to self-isolate outside the centre be needed.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

A sample of resident files reviewed demonstrated that residents' annual review meetings had taken place recently. It was noted that residents chose not to attend, and where family members were invited, they had declined. The meetings involved multidisciplinary support staff and reviewed health, communication and social care needs.

Inspectors found some residents nursing interventions plans and risk assessments had not been updated to reflect residents' mental health risks, however this is included under risk management.

Judgment: Compliant

Regulation 6: Health care

Residents had access to appropriate health information and access to health assessments and health care professionals as required. One resident that had raised

their health concerns with inspectors and was losing weight had been referred for medical investigations.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had put measures in place to support staff to manage behaviours of concern in the centre. There was also evidence of ongoing reviews of behaviour support plans to ensure residents' behaviour support needs were being met. However, this was not consistent for all residents as one resident that had frequently left the centre without staff support, did not have guidance for staff on how to manage this risk in their behaviour support plan.

Although some staff had received training in positive behaviour support, it was not clear from the training records maintained in the centre that all staff had had refresher training in managing behaviours of concern.

Judgment: Substantially compliant

Regulation 8: Protection

Staff spoken with were aware of what to do to minimise the safeguarding risks between residents, and staff stated that consistent staff in place, who know the residents well was very important. However, residents continued to be at risk of physical and psychological abuse in one location in the centre. One resident told inspectors they did not feel safe living in Dunwiley.

In addition, inspectors found the overarching safeguarding plans that were in place for residents were non-specific, which created a risk that staff would not be aware of all of the specific safeguarding concerns between residents.

Judgment: Not compliant

Regulation 9: Residents' rights

Inspectors noted that residents had been referred for independent advocacy services to provide information about their rights. However, as this is a campus based setting, which relied on their main meals being provided from a centralised kitchen, this impacted on residents' decisions around meal choices and times. In addition, some residents did not feel safe living in the centre due to the behaviours

of other residents, and this impacted on the peaceful enjoyment of their own home.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially 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	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Dunwiley & Cloghan OSV-0005489

Inspection ID: MON-0032540

Date of inspection: 02/09/2021

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	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15: Staffing the following actions have been undertaken:</p> <ol style="list-style-type: none"> 1. The Person in Charge has assigned a consistent cohort of staff for the centre supplemented by a regular number of agency staff assigned for the centre to ensure continuity of care for all residents. Completion date: 30/09/21 2. The Person in Charge and the Director of Nursing will continue liaise with HR in relation to absence management. Completion date: 31/12/21 3. The Person in Charge and Director of Nursing will establish a roster to ensure that the centre will be stand alone. Completion date: 31/12/21 	
Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16: Training and Staff Development the following actions have been undertaken:</p> <ol style="list-style-type: none"> 1. A full review of training requirements for the centre has been undertaken. Completion date: 30/09/21 2. The Person in Charge has schedule all outstanding training Completion date: 30/09/21 	

3. The CNM3 Quality Risk & Service User Safety will complete refresher training with the Person in Charge on the CHO1 revised training matrix.
 Completion date: 30/11/21

4. The Person in Charge will monitor scheduled training and the training matrix on a monthly basis
 Completion date: 30/11/21

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
 To ensure compliance with Regulation 23: Governance and management the following actions have been undertaken:

1. The Person in Charge has commenced a review of the systems in place for Resident's feedback in consultation with the Psychology, Speech and Language Therapy and the Safeguarding and Protection team.
 Completion date: 30/11/21
2. The Person in Charge has ensured that one to one time is provided to Residents where they require same. This will be recorded in their daily activity schedule and any issues of concern will be address in a timely manner
 Completion date: 11/10/21
3. Resident x1 will be transitioned to their new accommodation
 Completion date: 30/11/21. For a second residents a service provider has been identified and transition plans for their relocation are currently being progressed.
4. In relation to the resident who spoke with the inspector on the day of the inspection an MDT meeting was held to discuss and agree what actions were required to support the resident in feeling safe in their home and to agree an action plan going forward.
 Completion date: 16/09/21

Regulation 26: Risk management procedures	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
 To ensure compliance with Regulation 26: Risk Management Procedures the following actions have been undertaken:

1. The Person in Charge in liaison with the CNM3 Quality Risk & Service User Safety and each named nurse has commenced a review of all Risk Assessments.
 Completion date: 30/11/21
2. The Person in Charge will ensure that all documentation links, any gaps previously

<p>identified are clear and a cohesive plan is put in place. Completion date: 30/11/21 3. The Person in Charge will continue to attend monthly Quality, patient safety meetings Completion date: Completed 30/09/21</p>	
Regulation 7: Positive behavioural support	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: To ensure compliance with Regulation 7: Positive Behavioral Support the following actions have been undertaken:</p> <ol style="list-style-type: none"> 1. The Person in Charge has commenced a review all Behaviour Support Plans in liaison with the MDT and CNS in positive behaviour support. Completion date: 15/11/2021. 2. The Person in Charge has conducted a full review of training requirements in relation to positive behaviour support and has scheduled refresher training as required. Completion date: 30/11/2021. 	
Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection: To ensure compliance with Regulation 8: Protection the following actions have been undertaken:</p> <ol style="list-style-type: none"> 1. The Person in Charge has liaised with MDT, Safeguarding and Protection Team to review all Overarching Safeguarding plans Completion date: 15/11/2021. 2. The Person in Charge will continue to attend monthly multi-disciplinary safeguarding meetings to ensure further oversight and involvement in relation to safeguarding plans. Completion date: 31/10/21. 3. The Person in Charge will continue to attend monthly Quality, patient safety meetings to ensure oversight and governance in relation to incident management. Completion date: Completed 30/09/21 4. The Person in Charge has assigned a consistent cohort of staff for the centre supplemented by a regular number of agency staff assigned to the centre. Completion date: Completed 30/09/21 5. The Person in Charge and Director of Nursing will establish a roster to ensure that the centre will be stand alone. Completion date: 31/12/21 	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance with Regulation 9: Residents Rights the following actions have been undertaken:

1. The Person in Charge and Director of Nursing will work with each resident and their advocates to ensure they understand meal choices in terms of preference.

Completion date: 30/11/21

2. The Person in Charge has ensured that there is a varied choice of food in each house to ensure that residents can make a snack or be assisted in doing so as an alternative to what is provided.

Completion date: Completed 19/04/21

3. The Person in Charge has liaised with MDT, Safeguarding and Protection Team to review all Overarching Safeguarding plans.

Completion date: 15/11/2021.

4. The Director of Nursing and Provider Representative are in discussion with the housing association in relation to reconfiguring the layout of the centre. Initial discussions commenced on 23/09/21 and plans have been shared. Further engagement required to complete the reconfiguration.

Completion date: 31/03/21

5. Resident x1 will be transitioned to their new accommodation

Completion date: 30/11/21. For a second resident a service provider has been identified and transition plans for their relocation are currently being progressed.

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 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/12/2021
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	31/12/2021
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	Substantially Compliant	Yellow	30/11/2021

	development programme.			
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	30/11/2021
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.	Substantially Compliant	Yellow	30/11/2021
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.	Substantially Compliant	Yellow	30/11/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that	Substantially Compliant	Yellow	30/11/2021

	is challenging including de-escalation and intervention techniques.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2021
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.	Substantially Compliant	Yellow	31/12/2021
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	31/03/2022
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	Substantially Compliant	Yellow	31/03/2022

	exercise choice and control in his or her daily life.			
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