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:	Blath na hOige Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	20 July 2021
Centre ID:	OSV-0001769
Fieldwork ID:	MON-0032542

About the designated centre

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

The designated centre provides a residential service to three full-time residents and a respite service to one resident on two set nights per week. Residents using this service have a primary diagnosis of intellectual disability. The centre can accommodate residents with moderate to severe care needs and additional care needs such as epilepsy and sensory deficits. Residents are supported by a primary care team which consists of both social care workers and social care assistants. Additional social care hours are deployed in the centre in response to residents' social needs. Both night duty staff and a sleep in arrangement are in place to meet the needs of residents. An integrated service is offered to one resident in the centre and all other residents access day services away from the centre. The centre comprises of one house and each resident has their own bedroom. There is also ample communal, kitchen and dining facilities as part of the design and layout of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 - 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
Tuesday 20 July 2021	09:30hrs to 17:00hrs	Thelma O'Neill	Lead
Tuesday 20 July 2021	09:30hrs to 17:00hrs	Alanna Ní Mhíocháin	Support

What residents told us and what inspectors observed

In this centre there was evidence of a good quality, person-centred service that addressed the needs of the residents and promoted their independence. The governance and management of the centre ensured that the residents were in receipt of an individualised service that enabled them to make choices about their daily lives, however inspectors observed some improvements were required in relation to fire safety, the premises, and risk management.

Inspectors met with three residents who live in the centre full-time and one resident who attends the centre for respite. Residents were busy going about their daily routines and met with inspectors at various times throughout the day. The residents all present with different communication styles and engaged with inspectors on their own terms. Some discussed their plans for the day and upcoming week which they were excited about. Three of the residents had visual impairments and required 1:1 staffing with social activities and activities of daily living.The residents were supported by staff to communicate with inspectors. Residents appeared at ease with staff and relaxed in their home.

On entering the house, the inspectors observed that the house was clean and welcoming. A COVID-19 sanitisation station was set-up at the front door, and inspector adhered to public health guidance on the prevention of infection of COVID-19 throughout the inspection. The centre was personalised with residents' photographs on the walls in the hall. The centre had a homely feel with comfortable furniture. Overall, the centre was in good decorative and structural repair. The living room had recently been redecorated and was very cosy with comfortable couches and colourful cushions. The kitchen/ dining area was bright, airy and spacious and had access to the back garden via the utility room.

In addition to the living room, there was also a den with a television, armchair and shelving unit. Inspectors were told that one resident in particular liked this room to relax in, however, inspectors noted that the satellite box was at a height and not appropriately secured and posed a risk of injury if it fell. The bedrooms were nicely furnished and staff reported that residents had input into the design. Residents independence was promoted through the use of certain furnishings, for example, open cube-shelving with baskets to allow residents to more freely access their belongings. The bedroom used for respite service a few nights a week, had a pull-out couch in addition to the resident's bed. This couch was used by sleep-in staff when the resident was not staying in the centre. The suitability of this furniture in a residents bedroom had not been adequately assessed, as it took up a lot of the accessible space in the bedroom, and could be a hazard to the resident who was visually impaired and used this room.

Fire doors were installed on all bedrooms. However, they were not fitted with self-closing devices, as three of the residents living in the centre were visually impaired, the use of self-closing door devices would enhance access to their bedrooms, while

also maintaining the fire safety requirements.

There was one main bathroom for use by all 4 residents. The design and layout of this bathroom was not conducive to promoting the residents privacy, as it was accessed by two doors. It also allowed for the bathroom to be used a throughway in the house from the utility room to the hall which posed an infection control risk.

Outdoors, there was a pleasant area for sitting out with opportunities for gardening using raised beds, sensory gardening activities, and a swing-set for fun. There was also a wooden chalet that was used as a chill-out space for one resident and had been nicely decorated by the resident's family.

Inspectors observed that the resident's rights were being upheld by offering and respecting their choices. Residents were included in decisions about activities in the house, for example, planning the weekly menu. Staff used a range of strategies to interact with residents. An 'object of reference' communication system had been introduced in the house for some residents with objects located in an accessible shelving unit in the hall and kitchen. This allowed residents to express their choice and was also used as a way to communicate the sequence of events and daily plans to residents who were non-verbal or visually impaired. Residents were supported in pursuing their interests and enabled to spend their day in the community or at home if they wished.

The residents seemed very comfortable with the staff. Staff interacted with the residents in a very friendly, warm and respectful manner. The person in charge and staff members who met with inspectors were very knowledgeable of the residents' backgrounds, needs, preferences, communication style, interests and dislikes. Residents and staff appeared very relaxed and comfortable in each others' company. Staff spoke about the residents in a very warm and respectful manner.

Residents were supported to maintain connections with their families with frequent visits and overnight stays. Staff supported the residents to engage in the community through the attendance at day centres, local gyms, swimming pools and walks in the local area. Staff had also planned taster activities for residents based on their knowledge of the residents' preferences.

Overall, the inspectors found that the service provided was person-centred and of a good standard. The centre itself is a pleasant home but there are some areas that require improvement. Inspectors observed that the staff showed empathy and respect in all dealings with the residents and when they spoke about the residents. The residents were supported in their communication and daily activities. The residents' rights were respected. The daily practice and attitudes of the staff ensured that this was the case.

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

Capacity and capability

There were governance and management systems in place to ensure that the service provided was safe, consistent and appropriate to the residents' needs. However, improvements were required in the areas of fire safety management, premises and staff training and the governance and management of the service.

The centre was operated by Western Care Association and the centre was managed by the person in charge, who worked full-time in the centre and had the skills and experience to necessary to manage the centre. She had a good knowledge of the resident's needs and the arrangements in place to meet those needs.

While there was a robust management structure in the centre, the governance arrangements required review. The provider had completed unannounced audits and annual reviews as required by the regulations. The provider had requested the regional manager for the centre to complete an unannounced audit of the centre in May 2021, which had identified a number of actions that required addressing, one of these actions related to fire evacuation procedures and inspectors found this issue and other fire safety issues had not been adequately assessed or managed. Consequently, the provider was required to seek the expertise of a fire safety person to risk assess fire safety in the centre and submit a report to HIQA within five days of the inspection.

The person in charge had good knowledge of the staffing requirements and necessary skill mixes. There was a long standing staff team working in Blath na hOige which ensured continuity of services for all residents. The person in charge confirmed to the inspectors there was adequate staff on duty in the centre to meet the care and support needs of the residents and from review of the staff rosters the staffing allocation was adequate to meet the health and social needs of the residents with additional staff available at certain points in the day to facilitate the residents' social activities. However, there were changes in staffing from a waking night staff to a sleepover staff one night a week, but this arrangement was not adequately assessed in terms of fire safety evacuation procedures and the centre's fire evacuation plan.

Staff reported that they felt supported in their role and were able to voice any concerns that may arise. Staff training had been provided in key areas pertinent to this service and the needs of the residents. It was noted that mandatory training refresher courses had not been completed by some staff. The person in charge provided assurances to inspectors that she would seek dates for these training courses to be completed within a short time frame, however, inspectors found this issue was previously identified in the provider's own unannounced audit in May and had not yet been addressed.

Inspectors also reviewed the provider's application to renew the registration of this centre as part of this inspection, but on review, they did not meet the requirements

set out in the regulations, for example, the floor plans, residents guide and the Statement of Purpose.

Staff who were directly supporting residents were kind and empathetic in their interactions. They showed a familiarity and warmth to residents who appeared very comfortable and relaxed in their company. Staff members were knowledgeable on all residents. Each resident had a key staff member who took responsibility for their support and personal development which worked well in promoting the resident's ability to engage in daily activities.

Registration Regulation 5: Application for registration or renewal of registration

Documents submitted as part of the application to renew the registration of this centre were reviewed as part of this inspection and found that they did not meet the requirements set out in the regulations.

For example;

1. The floor plans did not clearly specify the purpose/ use of each room. For example, staff bedrooms/ office, residents bedroom/ staff bedroom.

2. The residents guide did not clearly detail all of the requirements under Regulation 20

3. The statement of purpose did not clearly identify all of the service provision and facilities available in the centre, for example, the specific care and support needs of the residents, or the arrangements at night for waking/ sleepover staff and the special care and support needs of the residents.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The person in charge demonstrated good knowledge of the residents' needs and the staffing requirements of the service. Good oversight of the service was evident through effective governance and operational management of the centre.

Judgment: Compliant

Regulation 15: Staffing

The number, qualifications and skill mix of the staff was appropriate to the needs of the residents in this centre. Continuity of care and support was evident through the use of a key staff member for each resident.

Judgment: Compliant

Regulation 16: Training and staff development

Staff training was not up to-date and staff required refresher training in managing behaviours of concern and medication management. .

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not adequately assessed and managed risks in this centre, in relation to fire, premise issues, and delays in providing staff training. In addition, documentation submitted as part of the application to renew the registration did not meet the criteria and required review to complete the registration renewal. While the provider had arrangements in place to audit the service, it was not robust, as there were actions that were not completed or identified as part of the provider audits.

Judgment: Substantially compliant

Quality and safety

Residents' well-being and welfare was maintained by a good person-centred service in this centre. However, improvements to patient safety was required in relation to the regulations governing fire precautions and the layout of the premises, staff training, and risk management.

This centre was a bungalow style dwelling, the centre itself was comfortable, clean and homely. However, the design and layout of the premise was not always conductive to a relaxing environment, as access to certain parts of the house were through communal rooms. For example, residents and staff had access to the utility and kitchen from the main bathroom, which had two doors and was used at times as throughway to the residents' bedroom area. This was not ideal and could create an infection control risk in the centre, which had not been identified by the provider

in their environmental risk assessments.

On review of fire safety management in the centre, inspectors found significant risks in the centre in a number of areas, that were impacted by the design and layout of the building and the reduced staffing support at night. The fire evacuation procedures in the centre had not identified or addressed these issues. In particular, inspectors found there were a number of risk associated with evacuating the premises taking into consideration the particular vulnerabilities of the residents who had hearing and visual impairments. These residents were assessed as needing 1:1 staff support to evacuate. One evacuation risk identified by the inspectors that had not been risk assessed was an inner room, namely a toilet and hallway which were only accessible directly from the kitchen/dining room. In the event of a fire, residents could only evacuate through this hallway, which also stored the electrical fuse board. Inspectors observed that there were no smoke seals on the fire doors in this hallway and the intumescent strips appeared to be painted over which could impede their effectiveness in the event of a fire. Evacuation was directly into the kitchen/dining room area and the kitchen sensor was a heat sensor which does not detect smoke and would only sound when there was a serious fire in the kitchen. As the residents had hearing and visual impairments this was an additional risk, as they would not be alerted to the fire while in the toilet. From discussions with staff on the centres fire evacuation procedures, inspector found there was not appropriate arrangements in place or risk assessments completed to ensure residents could be safety evacuated from this area in the event of a fire.

Although, frequent fire drills had taken place in this centre and documentation in relation to this was provided to inspectors, inspector found they had not completed fire drills on their reduced staffing support at night: for example, one night a week the waking night staff support changed to a sleepover staff and these changes in their staffing arrangements were not risk assess to ensure the minimum staffing support at night was adequate to safely evacuate the residents in the event of a fire. This change to the night-time staffing arrangement was not identified in the fire evacuation plan, and it was not clear which of the sleepover staff should take the lead to direct the fire evacuation in this situation. Inspectors found on discussion with staff about the fire evacuation procedures, while they were aware that each resident required 1:1 support to evacuate, they were not clear on the fire evacuation procedure.

The fire detection and warning system was located in the staff bedroom/ office and its location was not outlined in the centre's evacuation plan. Furthermore, although the centre's fire evacuation plan outlines three zones within the centre, the fire alarm panel did not identify zones within the centre to aid in the locating of the fire, and resulting in the staff having to manually go and locate the fire before implementing the evacuation of the centre.

Inspectors observed fire doors being held open by furniture in the staff bedroom/ office, as they did not have appropriate hold open devices installed. There were also hazards stored in the hallway that were directly outside the residents' bedroom, which could impede the safe evacuation of the centre in the event of a fire and had not been risk assessed. These issues were highlighted to the provider on the day of

inspection and the provider was required to make appropriate arrangements for the centre to be fire risk assessed by their fire safety expert and to submit a report to HIQA with assurances or a plan within 5 days on how they are going to address these fire issues in the centre.

A review of risk management in the centre found that a central log of accidents and incidents was kept and analysed by the person in charge and incidents were risk-rated and escalated to appropriate multi-disciplinary team or the regional manager as required. Support was sought from professionals within the service if needed, for example, behaviour support specialists.The provider also had arrangements in place to record centre-specific and person-specific risk assessments. However, inspectors observed a hazard in a communal room in relation to television equipment that was not safely secured at a height and could cause an injury to residents or staff. Also, risk documentation regarding COVID-19 and fire was not clearly recorded on the centre's risk register.

Staff spoke about each resident in a caring manner and demonstrated in-depth understanding of each individuals' capabilities, preferences and needs. Inspectors observed staff interacting with residents throughout the day and it was noted that residents were offered choices in relation to their food preferences, activities, etc.

Each resident presented with different communication needs and an individualised approach had been taken by staff to support the residents in this regard. This enabled residents to make choices and enabled staff to inform residents of the next daily activity planned for the day. Objects used for communication were placed in accessible locations throughout the house and inspectors observed their use by staff throughout the inspection.

Residents were facilitated in engaging in social activities of their choosing. This was achieved through the key staff members working with the resident, the availability and use of a vehicle and through the goal setting outlined in the residents' personal plans.

The health needs of the residents were understood by the person in charge and staff. The residents had access to the relevant medical professionals that they required. Health plans were recorded and updated on a regular basis and routine appointments were planned in advance for the year. Staff demonstrated good knowledge of the risks and protocols relating to positive behaviour support for the residents However, there was a recent increase in incidents of behaviors of concern in the centre.On review, some positive behaviour support plans were not reviewed since 2018.

Staff were knowledgeable on the strategies needed to avoid, de-escalate and manage any behaviours of concern that may occur if a resident became distressed. Inspectors observed a staff member interact effectively with a resident in this regard.

In summary, this is a pleasant home but actions are needed in relation to the centre itself to ensure fire safety and a lay-out that promotes the residents dignity and privacy. Overall, inspectors found that the residents received a good quality service

where their healthcare, social needs and community involvement were supported and promoted.

Regulation 10: Communication

Residents were supported to communicate their needs and preferences through the use of a multimodal system, specific to each residents communication style. This system of communication was in use throughout the centre and used by all staff to good effect.

Judgment: Compliant

Regulation 17: Premises

The premises were clean and suitably decorated. However, action is needed to address the set-up of the den, the layout of the main bathroom and the use of one of the bedrooms.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk assessments were conducted, actioned and reviewed. A log of incidents and and learning from these events was noted. However, inspectors observed a hazard in relation to television equipment that was not safely secured. Also, not all risks identified by the provider had been logged to the risk register.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider has taken precautions against fire and conducted frequent fire drills. However, the provider has not made adequate arrangements for the evacuation of all people in the centre, particularly in light of the residents high support needs and the staffing arrangements at night when there are no waking night staff on duty and adequate plans for evacuation from rooms off the kitchen. The provider has not adequately demonstrated that they have maintained the building fabric to prevent the spread of fire; specifically fire door seals. The provider

had not assessed the need for magnetic self-closing locks to be fitted to the fire doors.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The personal plans viewed by inspectors were comprehensive and outlined the resident's health, personal and social care needs. They were reviewed within the last 12 months and actions were being taken to fulfil the goals of these plans.

Judgment: Compliant

Regulation 6: Health care

The healthcare needs of the resident were met by ensuring that the resident had access to healthcare professionals as required. An annual medical review was also planned for each resident.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff demonstrated good knowledge of the risks and protocols relating to positive behaviour support for the residents. On review, some positive behaviour support plans were not reviewed since 2018, despite ongoing behaviour management issues in the centre.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had arrangements in place to protect residents from all forms of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had the freedom to exercise choice in their daily activities. The centre was operated in a manner that respected their needs and wishes. Residents were supported to exercise their choice by supporting their communication and by providing adequate staff to accompany residents as they engaged in their preferred activities.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Not 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
Regulation 9: Residents' rights	Compliant

Compliance Plan for Blath na hOige Residential Service OSV-0001769

Inspection ID: MON-0032542

Date of inspection: 20/07/2021

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**
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: The residents guide has been amended to reflect requirements under regulation 20. The Statement of Purpose has also been amended. These documents have been resubmitted to HIQA for the registration process. On completion of installation of new fire door, floor plans will be resubmitted to reflect the change.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has liaised with the Training Department with regards to upcoming dates for training. Staff have already completed their MCB refresher training on 11/08/21, with the remaining staff completing their training by 16/10/21. Staff have also completed medication refresher training on 09/08/21 with the remaining staff completing their training by 10/09/21	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Documentation in relation to application for renewal of registration have been submitted to HIQA. Training for staff is scheduled and will be completed by 16/10/21. The PIC and Area Manager will continue to meet on a monthly basis to review and progress any	

actions identified within the centre. The service provider will continue to conduct twice yearly unannounced inspections of the service. PIC and Area Manager will review roster to facilitate more time off roster for the PIC.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Maintenance have addressed the concern highlighted for the Den and moved the TV & Sky box. The bedroom area will only be used for individual availing of respite. The layout of the bathroom is being considered at this time in line with the support needs of all residents with a particular emphasis on the specific needs of one individual. Protocols are in place for using this area while ensuring personal rights are respected and duty of care implemented which incorporate the individual's right to respect, privacy and dignity together with infection control management. These have been developed with input from the relevant MDT professionals.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Maintenance have addressed the concern highlighted for the Den and moved the TV & Sky box. The Risk Register has been reviewed and updated accordingly to include the fire risk register and updating all personal emergency evacuation plans.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: We have · Risk assessed and reviewed individual fire evacuation plans for all residents which are inclusive of all reasonable scenarios within the service. · All staff participating in fire evacuations. · All staff trained in fire safety. · High staffing levels to ensure residents are supported. · Replaced any damaged intermittent strips. · Additional smoke sensors added to the service. · All fire equipment is in place and checked. · Verified that our ceiling throughout the property meets the fire safety standard by having an expert carry out a biopsy of the ceiling to confirm we have half hour pink slabs installed including half hour stira. · Conduct weekly fire evacuations on Monday nights when two sleep ins are on duty. · Conduct regular evacuations to include when bathroom off kitchen area is in use. With respect to adequate plans for evacuation – following advice from fire officer, plans have been agreed with contractor, for the installation of an alternative fire door. This is part of the scheduled work which commenced on 23/08/21.	
Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Identified Behaviour Support Plan has now been reviewed by Behaviour Support Specialist, signed and dated to reflect this. This plan will be reviewed annually, unless required, before this. Staff have completed their MCB refresher training on 11/08/21, with remaining staff completing their training by 16/10/21.	

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Substantially Compliant	Yellow	19/08/2021
Registration Regulation 5(3)(f)	In addition to the requirements set out in section 48(2) of the Act, an application for the registration or the renewal of registration of a designated centre shall be accompanied by a copy of the written guide produced for residents in accordance with Regulation 20 of the Health Act	Substantially Compliant	Yellow	19/08/2021

	2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 and an example of any brochure or advertisement used or to be used for the designated centre.			
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	16/10/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	19/08/2021
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	Substantially Compliant	Yellow	19/08/2021

	to residents' needs, consistent and effectively monitored.			
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	19/08/2021
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	03/09/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	03/09/2021
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.	Not Compliant	Orange	03/09/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that	Substantially Compliant	Yellow	16/10/2021

	is challenging including de-escalation and intervention techniques.			
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	21/07/2021