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:	No 3 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	15 December 2021
Centre ID:	OSV-0005135
Fieldwork ID:	MON-0027095

About the designated centre

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

No 3 Seaholly is located in a suburb of Cork city on a campus run by the provider. A full-time residential service is provided to two adults. Those living in the centre may be autistic and have moderate/severe intellectual disabilities. Individuals may also require support with behaviours that challenge. The designated centre is a bungalow which has been divided into two apartment-style living areas. Both have been adapted to meet the individual needs of the residents. Each living area has a separate secure outdoor area, designed to meet each individual's needs. One of the areas has an all-weather surface which enables the individual to access the area all year round as they choose. The designated centre also has a staff office and staff bedroom. The centre’s focus is on meeting the individual needs of each person, by creating a homely environment. Individuals are supported to participate in household, social and leisure activities. The residents are supported by social care staff during the day with one waking staff and one sleep over staff by night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 15 December 2021	09:30hrs to 17:45hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

The residents living in the centre received a very individualised service tailored to their assessed needs. It was clear that positive relationships had been developed between the residents and staff team, some of whom had worked in the centre for many years. Throughout the inspection there was evidence that this model of service had supported the residents to enjoy a good quality of life and experience successes. These included attending appointments they previously found difficult and resuming preferred activities. The number of restrictions in use in the centre had also decreased. Some areas for improvement were identified and the recently appointed management team committed to addressing these.

This was an announced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

On arrival the inspector met with the person in charge of the centre. When in the centre, the inspector spoke with the social care leader. These staff had been recently appointed to these roles and demonstrated an extensive knowledge of the centre, the residents and their support needs. Later, the inspector also met with the person participating in management.

The centre was a two bedroom single storey house on a campus run by the provider on the outskirts of Cork City. The building had been divided so as to provide each resident with their own living areas. Due to the design of the building, which was based on residents' assessed needs, the residents did not interact with each other throughout the day. There had been recent occasions when the two residents had eaten meals together, including a barbecue outside. Residents were reported to enjoy these and more meals together were planned including a Christmas dinner.

The centre was clean and decorated and a homely manner. Each resident had their own bedroom, bathroom, kitchen or kitchenette, and a living room area in which to relax. One resident's bedroom was observed to have bare walls and no storage facilities. Management advised that different options had been tried and it had been concluded that the resident was most comfortable sleeping in these surroundings. Clothes and other items were stored in another part of the centre, with some accessible to the resident. One room in the centre had previously been used for seclusion. At the time of this inspection, management advised that this practice was no longer in use. Renovations were planned to this room in the new year. Both parts of the centre had been decorated in line with residents' preferences and interests. Due to the assessed needs of the residents, the provider was required to be innovative in how they did this. Murals were painted on the walls and soft items such as cushions had been personalised. Both residents enjoyed looking at photographs and these were on display throughout the centre. Both residents had access to an outside area. For one of the residents equipment had been installed in

line with their interests. The value of this area to this resident was highlighted by relative in a questionnaire they completed.

The inspector had the opportunity to spend time with one of the residents. They appeared very at ease in the centre and with the support provided by staff. It was clear that staff had a good understanding of how this resident communicated and also of their interests and abilities. All interactions observed were warm, unhurried and respectful. The other resident had been supported to go on an outing prior to the inspector's arrival. Staff demonstrated a very good understanding of what both residents found difficult, such as staff wearing masks, and both anticipated and planned support to help residents cope with these challenges.

Both residents received support from a day service staff from 9am to 3pm, Monday to Friday. This allowed for an individualised day service program based from the designated centre. Each resident received one-to-one support when in the centre and was assessed as requiring additional supports when in the community. At night there was one waking staff and one sleepover staff working in the centre. Management advised that if required additional staffing support could be accessed overnight. There was no record of this additional support being required in recent months.

As well as spending time with a resident in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. The centre's risk register was reviewed and while comprehensive and recently reviewed, further revision was necessary to ensure that the risk assessments were accurate and reflective of the centre. The inspector also looked at both residents' individual files. These included residents' personal development plans, healthcare and other support plans. These were generally of a good standard. Areas for improvement were identified and will be outlined in more detail in the remainder of this report.

As this was an announced inspection, resident questionnaires were sent to the provider in advance. One was completed by relatives of both residents living in the centre. Overall the feedback received was very positive. The staff team were praised for their 'care and commitment' and were described as extremely friendly and respectful. Any complaints made by relatives were reported to have been taken seriously and addressed straight away. The importance of a regular, familiar staff team was also highlighted. The inspector had also been informed of this by staff that they met in the centre and it was clear that management viewed establishing and maintaining a core staff team as a priority.

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

Overall, good management practices were seen. The provider adequately resourced the centre and provided the required supports in order to improve the quality of life of residents. It was evident that management were very responsive to issues as they arose in the centre. While there was evidence of a good level of oversight of the care and support provided in the centre, greater oversight and clarity was required regarding the restrictive practices in use in the centre. The person in charge informed the inspector that there were already plans underway to address this matter.

There was a clearly-defined management structure in place that ensured that staff were aware of their responsibilities and who they were accountable to. The team leader reported to the person in charge. The person in charge fulfilled this role for one other nearby designated centre on the same campus. They reported to the person participating in management.

The person in charge was employed on a fulltime basis. They were rostered to work in this centre once a fortnight and were in contact with, and available to, the staff team every day when working in the adjoining centre. Staffing was provided in the centre in line with the staffing levels as outlined in a statement of purpose. At the time of this inspection there was a regular team supporting the residents, some of whom had worked in the centre for many years. Some relief staff had been recently recruited to the team. Continuity of care was very important to the residents. Regular staff meetings took place in the centre. Management informed the inspector that staff supervision had not taken place at the required frequency that year. A plan had been put in place to address this issue in 2022.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is required by the regulations. There was evidence that actions devised to address identified issues had been completed. This included an aim to reduce the number of day service staff working with each resident so as to increase consistency. The most recent unannounced visit had taken place in July 2021. There was evidence that the social care leader had completed the actions outlined in the visit report.

Staff advised that administration of medications during incidents of anxiety had not been reported to HIQA as its use was not considered a restraint or restrictive practice. However there was reference in the record of the most recent multidisciplinary review of this resident's personal plan, and in a provider unannounced visit report, that the use of this medication was a restrictive practice. The person in charge advised that she was aware of this inconsistency and had planned a review meeting to address this matter.

It was also identified that greater monitoring and oversight of the administration of PRN or 'as needed' medications was required. The written guidance in place for the

administration of these medications at times of anxiety had been recently reviewed. The inspector reviewed the administration records of this medication and noted that these were not always consistent with the PRN guidance in place at the time. For example, it was written in the guidelines in place before November 2021 that both medications were to be administered together. However administration records showed that this direction was not always followed. The person in charge was very familiar with the most up-to-date guidance and advised that any administration of these medications would be closely monitored by the management team to ensure it was consistent with the medical advice given.

The inspector reviewed staff training records. Some gaps were identified. Three staff required fire safety training. These staff had completed evacuation training in the centre in the month of the inspection. Three staff required training in the safe administration of medication and the management of behaviour that is challenging including the escalation and intervention techniques. Both were scheduled for March 2022. Management informed the inspector that none of these staff would administer medication until the required training was completed.

The statement of purpose is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos and governance arrangements and the staffing arrangements. On review, it was noted that in places the information included was not specific to this centre and the two residents living there, for example it was not clear what day service arrangements were in place for the residents. While in the centre it was clear that the residents do not share a bathroom, as was outlined in the statement of purpose. Management explained that if one resident wished to access the bath this would be facilitated however they preferred to shower. The inspector asked that the statement of purpose and floor plans reflect the usual practices of the centre. During the inspection assurance was provided that the staff who worked at night reported the person charge. This reporting arrangement and the role of the night supervisor needed to be clearly documented in the organisational structure outlined in a statement of purpose.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

Staffing was provided in the centre in line with the staffing levels as outlined in a statement of purpose. There have been recent recruitment of relief staff to ensure residents received continuity of care and support. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Some staff required training in the management of behaviour that is challenging including de-escalation and intervention techniques, fire safety and medication management. This training was scheduled for March 2022.

Judgment: Substantially compliant

Regulation 21: Records

Not all records in relation to each resident had been accurately maintained. This posed a risk as the most up-to-date and accurate information about residents was not readily available to the staff team supporting them. In one instance guidelines for the use of a discontinued restrictive practice were still available in a resident's file.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider ensured that insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

Although there was evidence of strong oversight in many areas of service provision, improvement was required in the oversight of restrictive practices, review and progress of residents' plans, the fire safety precautions in place in the centre and and maintenance of residents’ records. Staff supervision sessions had not been held at the frequency outlined in the provider's policy.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to accurately reflect the organisational structure, including the role of the night supervisor, in the designated centre. The arrangements regarding the use of bathrooms in the centre also required review to accurately reflect the situation and practices in the centre.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained, and where required, these were notified to the Chief Inspector within the timelines outlined in the regulations.

Judgment: Compliant

Quality and safety

The inspector found that the quality and safety of care which was provided was maintained to a good standard. A review of documentation and the inspector’s observations indicated that the support approach implemented was very respectful of residents’ individual needs and wants. It was clear that residents’ rights were promoted and they appeared to enjoy a living in the centre. Areas for improvement

were identified. These included elements of residents' individual plans as well as documentation, fire precautions and the risk assessment of hazards in the centre.

The inspector reviewed residents' individual files. It was noted in both of the residents' files that they required two-to-one staff support in all aspects of their lives. Management informed the inspector that this related to support outside the centre only and the documentation would be updated to reflect this. When looking through both files it was noted that there was often duplication of documents. It was not always easy to tell which was the most up-to-date version. It was also identified that, despite management informing the inspector that it was no longer used in the centre, one resident's file still included a 2021 protocol on the use of seclusion. The person in charge advised that a review of the personal plan files was planned.

Residents' files were comprehensive and included their personal histories, their likes and dislikes, what was important to them and individualised support plans. A detailed plan outlining the residents' night-time routines had been recently developed. Both residents' personal plans had been reviewed with the involvement of multidisciplinary professionals in the last 12 months, as is required by the regulations. Where required, residents had a recently reviewed behaviour support plan.

At times, residents were administered medications in advance of medical procedures to support them to cope with these challenging situations. Administration of these medications in these circumstances had been reported to HIQA, as required. However the written guidelines in place only referred to the administration of these medications for incidents of anxiety. Additional specific guidance was therefore required.

There was evidence that the provider ensured residents' healthcare needs were met in the centre. Staff had recently supported both residents to have dental check-ups. This had been a challenge for one resident in the past. There was evidence of regular input from their general practitioner and other allied healthcare professionals as required. It was identified that one healthcare plan required review to ensure that it was up to date and reflective of the resident's current presentation. This plan had been developed in response to an assessed high body mass index (BMI), however most recent concerns related to this resident experiencing significant weight loss. It was also noted that the effectiveness of healthcare plans was not documented. It was therefore not possible to tell if the plans in place were successfully addressing residents' identified healthcare needs.

Both residents had a personal development plan outlining what was important to them and the goals they would like to achieve in the coming year. When reviewing these plans, it was noted that the reviews of goals were not specific. For example, the documented review may provide an update on the resident's general welfare or activities since the last review but this information did not necessarily relate to the specific goal in their plan. It was therefore not always possible to see progress regarding the resident's goals.

It was clear that staff had a good knowledge of the activities residents enjoyed. These activities and places that residents enjoyed to spend their time were documented in their file. One resident had recently gone swimming for the first time following a prolonged break. This achievement had taken considerable planning and sensitive support from the staff team. It was hoped to regularly continue with this activity.

It was demonstrated throughout the inspection, through conversations with staff and a review of documentation, that residents' rights were promoted in the centre. The use of a number of restrictions had been discontinued and where restrictions had been assessed as necessary there were ongoing efforts to reduce the impact of these restrictions on residents' rights. Despite this, it was noted that the restrictions in place in the centre had not been reviewed in the previous 12 months, as required by the provider's own policy. The person in charge informed the inspector that this review was scheduled for January 2022. As discussed in the 'Capacity and capability' section of this report additional clarity and oversight in the area of restrictive practices was required from management.

As outlined in the opening section of this report, the centre was warm, clean and decorated in a homely manner. Some minor maintenance works were required and these were planned or requested on the day of inspection. These included painting required in a bedroom and repair to the flooring in one bathroom. It was noted that the fire door between a main corridor and the kitchenette area was damaged. The inspector requested that a competent person review the door to ensure that it would still be an effective containment measure if required during a fire.

The inspector reviewed the fire safety systems in place in the centre. Systems were in place and effective for the maintenance of the fire detection and alarm systems, including emergency lighting. Each resident had a recently reviewed personal emergency evacuation plan (PEEP). It was documented in their PEEPs that if required residents may be supported to evacuate using wheelchairs. However one of these wheelchairs was stored in a shed outside the main building. This storage arrangement required review to ensure that the wheelchair was readily accessible if required. In two of the last nine drills completed, one resident had refused to evacuate. Despite this, the use of a wheelchair had not been offered, in line with their PEEP. It was also noted that the location of the fire was not specified in the drill, it was therefore unclear if residents had experience using all of the available evacuation routes. Although there was evidence that regular fire drills had been completed, documentation was not available reflecting drills completed in night-time conditions. Management advised that they would arrange such a drill the following week. When in the centre the inspector asked to be guided to the assembly point. While doing this it was identified that a lock on one outside gate could not be opened and that the path to the assembly point was obstructed by a recently fallen tree. Both of these issues were addressed before the close of the inspection.

The inspector reviewed the centre's risk register. Although comprehensive the ratings required review to ensure that they were reflective of the actual risks posed

by identified hazards. For example, the rating regarding the impact of a resident moving in front of oncoming traffic was not accurate.

Regulation 13: General welfare and development

Residents had opportunities to participate in activities in line with their wishes, interests and assessed needs. Staff had a good knowledge of residents' preferred activities. One resident had recently been supported to return to swimming. Staff were planning increased opportunities for the residents to spend time together, following shared meals that both residents enjoyed.

Judgment: Compliant

Regulation 17: Premises

The premises were clean, accessible and decorated in line with residents' interests and preferences. Parts of the centre were in need of maintenance such as painting and repairs to flooring.

Judgment: Substantially compliant

Regulation 20: Information for residents

The guide prepared in respect of the designated centre met all of the requirements of this regulation.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk register had been recently reviewed. It was identified that further review was required to do ensure that the risk ratings were reflective of the risk posed by the hazards identified in the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19. Good practices in line with the centre specific guidelines and provider's policies were observed on the day of inspection.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire detection and alarm systems and equipment were available in the centre. Regular evacuation drills had taken place, however one had not been completed in night-time conditions. A fire door required review to ensure that it was fit for purpose as a containment measure. The storage of equipment to aid evacuation also required review. Barriers including a gate that could not be opened and a fallen tree were identified on one of the routes to the assembly point. Both of these matters were addressed during the inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal and social care needs of each resident had been completed. Each resident had a personal plan. Some plans required review to ensure that they were reflective of the residents' current needs and the contexts in which they were implemented. The effectiveness of some plans needed to be assessed to ensure they were addressing residents' identified healthcare needs. Improvements were also required in the review of residents' goals.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners and allied health professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required one had a recently reviewed behaviour support plan in place. The restrictive procedures in place in the centre had not been reviewed in the previous 12 months, as required by the provider’s own policy. The staff who required training in the management of behaviour that is challenging is addressed under Regulation 16.

Judgment: Substantially compliant

Regulation 8: Protection

There were, and had been, no recent safeguarding concerns in the centre at the time of this inspection. All staff had received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The designated centre was operated in a manner that respected the residents' individual needs. Residents were encouraged and supported to increasingly exercise choice and control in their daily lives. This was an ongoing focus of the staff team. Practices in the centre were consistent with maintaining residents' privacy and dignity.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially 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 No 3 Seaholly OSV-0005135

Inspection ID: MON-0027095

Date of inspection: 15/12/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A Schedule for staff training for 2022 is in place for HSE Land e-learning trainings and face to face mandatory training and the training needs of all staff has been identified.

Staff who require training/refresher training including in the areas of general fire safety, the administration of medication and the management of behaviors that challenge including escalation and intervention techniques are scheduled to complete this training by 30/04/22

The Provider runs a quarterly booking system and the Person in Charge will ensure staff training is kept updated using this booked system.</td></tr>
<tr><td>Regulation 21: Records</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 21: Records:
The Person in Charge together with members of the staff team has reviewed the residents' documentation folders to ensure that all information is up-to-date and accurate.

The records in relation to the administration of medication as a support to residents in advance of medical procedures will be reviewed to ensure that they provide additional specific guidance to staff in this regard.
Inactive reactive strategy guidelines will be removed to an archive folder where necessary [25/02/2022]
The PIC and Team Leader continue to work with behavioural support team in streamlining the paperwork for this designated centre.
The Provider has established a working group to review the process of reviewing the Behaviour Support Plans throughout the organization. This group is to report its</td></tr>
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recommendations in June 2022. The Person in Charge will ensure that the recommendations are implemented as necessary in this Centre. In addition the Provider has established a Documentation Review Group to review the overall paperwork/resident records system with a focus on reducing the amount of repetition currently within records. A pilot will take place in April 2022. The Person in Charge will ensure that the recommendations from the pilot project are implemented as necessary in this Centre

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider will ensure that the Staff Team are supported in distinguishing between supported measures in place to support residents and what should be considered a restrictive practice. Where medication is prescribed to support residents' anxiety the Provider and Person in Charge will ensure that the residents documentation clearly identifies if this is a support or a restrictive practice. All inconsistencies in the current documentation will be rectified.

A Restrictive Practice meeting took place on the 26th of January 2022 to review restrictions in place in the Centre. The restrictions will be reviewed moving forward in accordance with timelines set by the Behaviour Standards Committee

The residents Person Centred Planning meetings with the circle of support for each residents are set for 30/03/2022.

The Provider has ensured that there is a staff supervision plan in place and progress has been made with this. , All staff will have had a supervision session prior to the 31/03/2022 and there will be a schedule in place for a second supervision as per policy in the second half of the year.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of purpose will been updated to insure it includes more information specific to the Centre including clarification on
The usual use of the communal bathroom in the document including the fact that the use of the communal bathroom will be supported by the use of visual ensuring a total communication environment and also a protocol is being developed to ensure safe use of same for both residents. Completion date24/02/2022 and

- The reporting arrangement for night staff to the Person in Charge and the role of the night supervisor.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

The Provider will ensure that the premises is kept in a good state of repair and maintenance works carried out on a timely basis.

The floors repairs, soft room/chill out room new padding has been installed in January 2022.
Repairs and maintenance to walls and doors are in progress and completion for this work is scheduled for 25/03/2022.
A storage area for wheelchair identified as fire evacuation equipment will be identified internally in the Centre.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Provider has ensured that the Risk register is currently being updated and that the risk ratings are reflective of the presenting risks. This has involved reflecting a lower likelihood rating in some cases. [25/02/2022]

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Provider will ensure that

- regular fire drills will include simulated night evacuation drills and ensure that all residents experience using all of the available evacuation routes
- The Person in Charge will ensure that all staff are vigilant in ensuring evacuation routes are not obstructed at all times.
- Records of fire evacuations will include details of the location of the fire for the purposes of the drill.
- Fire Evacuation wheelchair equipment will be stored in the house and staff will ensure this is utilized during fire evacuation drills.
- Personal egress plans are currently in the process of being updated the new plans are to be discussed with all staff to ensure consistency on the 2/03/2022.
- Current fire doors have been determined to be fit for purpose, in order to future proof any further damage the Fire door in bathroom is to be replaced and is currently on order (25/03/2022)

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The individual residents Personal Plans will be reviewed to ensure that they reflect the residents' current presentation and that the effectiveness of health care plans is documented and the plans are updated if necessary.

Circle of support meeting to take place on the 30/03/2022,following on from this meeting a new updated plans with be implemented completion of this 29/04/2022

The Person in Charge will ensure that the specific goals identified in these plans are reviewed on a regular basis to ensure that the goals are progressing and that plan contains evidence of such reviews.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The Provider has ensured that a Restrictive practice review meeting took place on the 26/01/2022. Training for the management of behaviour that challenges has been set up for all staff members' completion of this 04/04/2022.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/04/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	25/02/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for	Substantially Compliant	Yellow	25/02/2022

	inspection by the chief inspector.			
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.	Substantially Compliant	Yellow	30/03/2022
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.	Substantially Compliant	Yellow	31/03/2022
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.	Substantially Compliant	Yellow	25/02/2022

Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	25/03/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	25/03/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	02/03/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	25/02/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or	Substantially Compliant	Yellow	29/04/2022

	circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	29/04/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	04/04/2022