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:	Bellavista
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	23 May 2024
Centre ID:	OSV-0001701
Fieldwork ID:	MON-0034029

About the designated centre

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

Bella Vista is a large community based designated centre operated by Sunbeam House Services CLG. The centre is located in an estate in a large town in Co. Wicklow. The house has ten bedrooms, a large living room, a kitchen/dining room, two bathrooms, a wet room and a small toilet room. The centre provides residential supports for up to eight adults, both male and female, with low to moderate supports needs. The centre is intended to support residents to live as independently as possible. The support provided to residents varies depending on individual needs and requirements. The current staffing compliment is made up of social care workers and care assistants with the staff team supervised by a person in charge. The person in charge divides their working hours between this centre and one other.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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
Thursday 23 May 2024	09:30hrs to 18:00hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

This was an announced inspection. The purpose of the inspection was to inform a registration renewal recommendation for the designated centre.

The inspection was facilitated by the person in charge and the deputy manager for the duration of the inspection. The person participating in management attended the inspection introduction meeting and met with the inspector later in the day with other senior management at the feedback meeting. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff and management, to inform judgments on residents' quality of life.

Overall, the inspector found that that the person in charge was striving to ensure that residents living in the designated centre were supported to enjoy a good quality life which was respectful of their choices and wishes. When speaking with the inspector, residents primarily spoke positively about living in the centre, and of particular note, was of their excitement and enjoyment of holidays in Ireland and abroad, attending concerts and sporting events.

However, the inspector found that residents were not living in an environment that was safe or provided the optimum living conditions. As a result there was an ongoing risk to the health and safety of residents. The lack of traction on plans to renovate the residents' home was impacting on the promotion of residents rights and in particular, their right to privacy and dignity, safety and independence.

On the day of the inspection, the inspector met with six of the eight residents living in the centre. The inspector observed residents coming and going to different community activities throughout the day.

In advance of the inspection, residents had been supported by staff to complete a Health Information and Quality Authority (HIQA) surveys. Overall, the four questionnaires relayed positive feedback regarding the quality of care and support provided to residents living in the centre. Residents enjoyed living in their home and were happy with the food provided. Surveys relayed that residents felt safe in their home and that staff were kind to them. Surveys noted that residents got along with the people they lived with.

On the day of the inspection, the inspector met and spoke with a resident and a number of their family members. The family relayed positive comments about the service and in particular, noted that there had been a lot of positive improvements since the person in charged had commenced their role in the centre in 2022. They told the inspector about their family member's birthday party that took place in the new outdoor pergola area and how enjoyable it was. They also referred to the different community activities and holidays residents living in the centre were were

supported to take part in.

However, they expressed their concerns regarding the continuity and consistency of care for their family member. During the conversation, the resident spoke with the inspector and said that they were not always familiar with staff that supported them. The family were concerned that not all staff were aware of their family member's needs or likes or of the special events occurring in their family member's life and how the importance of these events to them.

In early 2024, many of the residents moved out of the house for a period of time. The inspector was informed that residents went on holidays to different locations in the community and some residents went to stay with their family. During this time there was an upgrade of a downstairs bathroom into a wet room. Some other small upkeep and repairs were made to the house however, overall, planned renovations to the whole house (which had previously been discussed with residents and their families), had not gone ahead.

The centre was a large two story house large community house. The house comprised of ten bedrooms, a large living room, a kitchen/dining room, two bathrooms, a wet-room and a small toilet room. Each resident was provided with their own private bedroom which was decorated to their individual style and choice.

On walking around the house the inspector observed, for the most part, the physical environment of the house was clean and tidy. There was an array of pictures and photographs on the walls of the large sitting room. The inspector was informed that a recent change around of pictures and photographs on the wall had taken place to provide a fresher look to the room. A large fish tank in the sitting room provided an element of relaxation to the room. However, a staff computer and table at the top of the room, took away from the homeliness of the space.

The front hallway in the house included a seating area for residents to enjoy some quiet time. The information board on the wall of the hallway provided an array of useful easy-to-read information for residents, such as the complaints procedures, registration details, fire evacuation plan and information on the HIQA inspection.

The kitchen, which was just off the hallway, included a dining area. A new table and chairs had been purchased. There had been a small number of repairs to sections of the flooring however, none of the planned renovations or changes had been made. Overall, the kitchen cupboards and counter tops appeared worn and dull, areas of the skirting was observed to have chipped paint with rust observed on the radiator behind the kitchen table.

Outside the back of the house, a new seating area had been developed. The provider had secured a small lottery funding grant. There was a small pergola, new seats, a table and raised flower beds. There were some improvements to access from the kitchen to the outside area; hand rails had been installed and steps were painted bright yellow. The entrance to the outside laundry room also included yellow paint on the steps up to it. While these interim measures provider a better level of access for residents, they did not provide the optimum access and overall, were not

as per longstanding allied healthcare professional recommendations.

Walking around the laundry room the inspector saw that the kitchen sink area was unclean. Overall, a review of the layout and items stored in the room was needed. This was to ensure good infection prevention and control practices and also to prevent clutter related fire hazards.

Throughout the house the inspector observed a number of doors and frames in place to be scuffed, chipped and to have visible gaps underneath them. This meant that they were not an effective fire containment measure and posed a safety risk to residents living in the house.

In addition to the scuffed and chipped doors, the inspector observed a resident's bedroom flooring to be badly scrapped in areas, tiles in a bathroom to have dark grime on the grout, contact paper on the window to be worn and peeling, a window fan to be dirty and an mobility assisstive aid (bath-chair) in another bathroom, to be unclean. The upkeep and repair required throughout the house took away from the homely feel to the house. It also meant that there was an increased infection prevention and control risks to residents living in the centre.

The inspector spoke with a resident who, on a previous inspection, advised that they preferred to use the shower facility downstairs instead of using a bathroom next to their bedroom. Due to their mobility needs, access to the bath was difficult at times. The bathroom next to their bedroom was due to be changed in to a shower room as part of overall renovation plans for the centre. However, at the time of this inspection, this had not been addressed and instead a bath-chair had been provided for the resident as an interim measure.

The resident told the inspector that they now used the bathroom and the bath-chair independently but were unable to wash their hair while using the bath, instead they sat on the toilet seat and put their head over the sink and staff washed their hair for them. The resident told the inspector that they didn't need any assistance using a shower facility and could wash their hair independently. This meant that the provider had not put suitable planned arrangements in place to support residents' independence and their right to autonomy and privacy.

Residents were observed to appear comfortable in the presence of staff. The centre was observed to have a friendly and jovial atmosphere on the day of inspection. During the day, the inspector observed the staff sitting with and supporting a number of residents during their breakfast and dinner meals. The inspector observed staff to be mindful and caring when supporting the residents and overall, the mealtime event appeared to be a relaxed social event.

Previously, there had been a number of recent alleged safeguarding concerns relating to staff conduct which resulted in negative impacts for residents. A number of supports had been offered to residents such as mindfulness, massages and counselling sessions for a period of time. However, the inspector was informed that the impact to residents' wellbeing and mental health was still evident and that supports to date had not proved effective. This is discussed further under Regulation

8.

Residents participated in regular house meetings where they discussed household tasks, plans for the week, health and safety matters, advocacy, rights and household duties but to mention a few. Special topics were included at some meetings, for example the inspector read minutes of a meeting where healthy eating habits were discussed with a good level of participation from all residents attending.

In summary, the inspector found that overall, while the person in charge and staff were striving to ensure that residents' well-being and welfare was maintained to a good standard, improvements were needed to ensure residents were provided adequate and effective support at all times. Improvements were needed to the physical environment of the centre as well as to the fire precautions in place. This was to ensure that residents were living in a home that was safe and provided the optimum living environment. Improvements were also needed to ensure residents' rights were promoted so that their dignity, privacy and independence were promoted, at all times.

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

The provider had failed to take the appropriate steps to ensure that the designated centre operated within all of the centre's registration conditions. The provider had not adhered to the timelines and requirements as set out in a non-standard condition of their registration. As a result, residents were living in a house where there was ongoing risk to their health and safety, and where their rights were not promoted at all times.

The non-standard condition formed part of the centre's overall conditions of registration and was initially assigned to the centre's registration in May 2021 requiring the provider to bring the centres' premises (regulation 17), fire precautions (regulation 28) and governance and management (regulation 23), back into compliance by a specified date. During that time the provider had applied to vary the condition time-frames on two separate occasions.

The inspector observed that a number of actions from both the SMART time-bound plan and compliance plan had been completed. However, on the day of the inspection, there still remained a significant fire safety risk in the centre which meant not all the matters of the non-standard condition had been suitably implemented or addressed.

The outcome from an external fire door assessment saw the requirement for the

removal and replacement of 20 fire doors and frames. While a business plan had been submitted to source funding, there was no appropriate plan or timeline in place for the installment of the fire doors and frames. An urgent action plan was issued to the provider in relation to Regulation 28: Fire Precautions. However, the response received did not provide adequate assurances that fire safety upgrades that were required in relation to particularly to containment measures would be suitably addressed or actioned.

As raised on the previous inspection, the timeliness of the provider to bring the centre back into compliance and ensure the safety of the residents was not satisfactory and demonstrated poor capacity and capability of the provider to follow through on their commitments to the Chief Inspector to address key areas of non-compliance.

Notwithstanding the above, the provider had completed a number of provider led audits regarding the quality and care and support provided to residents in the centre. They provider had carried out a health and safety audit, a medication audit and an infection prevention and control audit in quarter one and two of 2024. In addition, the person in charge completed monthly household audits which monitored a variety of areas of service provision, to ensure better outcomes for residents. Furthermore, team meetings were taking place on a regular basis where shared learning and reflective practices occurred.

The staffing arrangements in place required review. There were a number of issues that potentially impacted on the provision of continuity of care to residents; There were three staff vacancies, there was a heavy reliance on agency staff and the majority of staff employed in the centre worked on a part-time basis. As a result, support provided to the residents was not always consistent and staff were not always familiar to residents. In addition, where one to one staff support was in place for two residents, improvements were needed so that residents were supported by familiar staff on a more regular and consistent basis.

Staff working in the centre had access to training as part of their continuous professional development and to support them in the delivery of effective care and support to residents. The training needs assessments demonstrated that overall, the majority of staff training was up-to-date, including refresher training. However, some deficits were found; To meet safeguarding plan requirements, and to best support residents mental health and wellbeing needs, specific staff training in this area was required.

Staff were provided one-to-one supervision meetings with the person in charge on a regular basis. The provider and person in charge were continuously endeavouring to find ways to better develop staff performance. The provider's most recent six monthly unannounced review of the centre found a number of gaps in residents' personal plan and associated records. While the person in charge raised the upkeep of residents' records at team meetings, as well as one to one staff supervision meetings, the inspector was informed that the issue remained on ongoing.

Improvements were needed to the information governance arrangements in place

that ensured the designated centre complied with notification requirements. The last inspection found that where restrictive practices were in use, that they had not been notified to the office of the Chief Inspector on a quarterly basis as required. This non-compliance had been identified on the previous inspection also. As such, the provider had not ensured quality improvements for previously identified deficits in their information governance arrangements.

Regulation 14: Persons in charge

The person in charge worked and was based in the designated centre on a full-time basis. The inspector found that the the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

The person in charge was support by a deputy manager, who supported them in their role.

Staff informed the inspector that they felt supported by the person in charge and that they could approach them at any time in relation to concerns or matters that arose.

Judgment: Compliant

Regulation 15: Staffing

There was an actual and planned roster in place and it was maintained appropriately by the person in charge. Two staff who spoke with the inspector on the day demonstrated good understanding of the residents' needs and of their individual likes and preferences.

There were three staff vacancies in the centre; The vacancies included one instructor and two social care worker roles. While these vacancies were being covered, the overall staffing arrangements were impacting on the provision of continuity of staffing in the centre.

The majority of staff working in the centre were working on a part-time basis, which in itself, posed a potential risk to the provision continuity of care to residents. Eleven staff members were working on average, three days a week. Currently, the person in charge and the deputy manager were the only staff employed on a full-time basis.

The person in charge was endeavouring to ensure continuity of care. The roster demonstrated that a number of part-time permanent staff worked extra shifts. There was a core team of relief staff who were employed by the organisation. The person in charge was also endeavouring to employ the same agency staff as much

as possible however, the roster demonstrated that this could not always be achieved. Overall, the roster demonstrated that there was a high usage of agency staff working in the centre.

On speaking with family members, the inspector found that they had raised a complaint with the provider regarding the consistency of care and support provided to their family member. In addition, the resident informed the inspector that they were not familiar with all staff supporting them.

The inspector reviewed the roster for a sample week of March, April and May 2024. Where a resident was provided 1:1 staff support for twelve hours a day, the review demonstrated that for the most part, the resident was support with five different staff members over a seven day period. On some of these weeks, agency staff were supporting the resident on 2 - 3 of the days.

Overall, the provider had not ensured that residents were provided with continuity of care. This had the potential to impact on staff developing and maintaining therapeutic relationships with residents, which is important in enabling residents feel safe and secure in their environment and protected from all forms of abuse.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector reviewed the schedule for staff training. The schedule demonstrated that staff were provided with training in safeguarding vulnerable adults, fire safety, infection prevention and control, speech and language and talk (SALT), safe medical management and manual handling, food hygiene, feeding, eating and drinking (FED first aid and manual handling, but to mention a few. Overall, the schedule showed that the person in charge was endeavouring to ensure that mandatory staff training was kept up-to-date, including refresher training. Where refresher training was due, courses had been scheduled for staff.

However, in relation to the provision of training that better supported residents' current or changing needs, improvements were required. The person in charge had identified and sourced specific mental health training to better supports staff in their role when supporting residents. In addition, the training was an action on a residents' safeguarding plan so that staff could effectively support residents who were impacted by recent safeguarding concerns.

The person in charge was providing one to one performance management meetings with staff on a regular basis. Staff who spoke with the inspector advised that the found the meetings very beneficial to their practice.

Judgment: Substantially compliant

Regulation 21: Records

The person in charge and deputy manager were aware of their roles and responsibilities regarding the management of records. The person in charge was aware that record keeping was a fundamental part of practice was essential to the provision of safe and effective care. The person in charge had an auditing system in place that was endeavouring to ensure that records were up to date, of good quality and accurate at all times and that they supported the effectiveness and efficient running of the centre.

On the day of the inspection, records required and requested were made available to the inspector. Overall, the records were appropriately maintained. Where there were gaps in records, for example personal plans, the person in charge and deputy manager were addressing these deficits with staff during supervision meeting and during staff meetings.

On the day of the inspection, the person in charge organised for staff records to be brought to the designated centre (from main office off-site).

On review of a sample of five staff files (records), the inspector found that they contained all the required information as per Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not ensured that residents were living in a house that provided the most optimum home environment in meeting their needs or in keeping them safe.

The provider had not carried sufficient fire safety upgrade works in the centre in order to bring Regulation 28: Fire Precautions back into compliance. The previous inspection found that, the majority of the recommendations on an external fire safety assessment May 2021 remained outstanding, a number which had been risk rated as high. The provider had since employed another external fire safety company to assess the containment deficits in the house, and in particular the doors. On review of the companies fire assessment proposal in April 2024, the inspector saw that 20 fire doors and frames were required to be removed and replaced.

While there were interim works completed to provide better access internally and externally for residents, the recommendations from the healthcare professional had not been completed to the optimum standard. The updated plan of major renovations works to the centre submitted to HIQA in August 23, noted that works would commence in January 2024 and be completed by August 2024 (previously a

date mid June 2023 had been provided). However, on the day of the inspection, the inspector observed that the renovation had not been completed.

On the evening of the inspection, during the feed back meeting, the inspector was informed that the planned renovations to the house were not going ahead and a new plan for de-congregation was under consideration. The inspector was advised by senior management that the the provider had determined the premises could not meet the long-term needs of residents. The provider had submitted an update on the progress of the original SMART time-bound plan actions in February 2024, however, had failed to indicate the change in plan for the centre, despite a pending renewal of the registration of the centre.

Overall, the impact of the timeliness to complete works that the provider has previously committed to action was not satisfactory and overall, resulted in negative outcomes for residents. There was a risk to residents safety in the event of a fire. The lack of upkeep and repair works, meant that residents right to independence, dignity and privacy was not promoted at all times. In addition, poor upkeep and repair meant that many areas in the house could not be cleaned effectively and posed a risk of the spread of health-care infections to residents and staff.

Judgment: Not compliant

Regulation 31: Notification of incidents

For the most part, the inspector found that there were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The person in charge ensured that incidents were notified in the required format and with the specified timeframes however, on the day of inspection the inspector found that improvements were required to ensure all quarterly notifications were submitted.

For example, two restrictive practices (relating to money management and internet usage), were not notified as required.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

There was an effective complaints procedure that was in an accessible and appropriate format which included access to an advocate when making a complaint or raising a concern. There was an easy to read information poster displayed in a communal area of the designated centre which included details of the complaints

officer. The complaints procedure was monitored for effectiveness, including outcomes for residents to ensure that residents received a safe and effective services.

There had been a recent complaint made, where a family had not been satisfied with the care and support provided to their family member and in particular, to the unsatisfactory consistency of care and continuity of staffing. On the day of the inspection, the inspector reviewed the progress of the complaint and saw that it had been followed up in a timely manner by the person in charge and senior management. A number of correspondence emails had occurred soon after the compliant was made. Further follow-up and meetings were planned for the week following the inspection. Overall, the inspector found that the complaint was being appropriately managed, in a timely manner and in line with the provider's policies and procedures.

Judgment: Compliant

Quality and safety

The person in charge and staff were aware of residents' needs and knowledgeable in the care practices to meet those needs. However, the inspector found that the governance and management arrangements in place were not effective in ensuring that a good quality and safe service was being provided to residents at all times. There were on-going fire safety and premises deficits that were posing a continuous risk to residents living in the centre. In addition, significant improvements were needed to the arrangements in place for the provision of positive behavioural supports as well as safeguarding supports. Furthermore, the inspector found that residents' rights were not promoted at all times and in particular, in relation to their right to dignity, privacy and independence.

The provider had not ensured that there was adequate precautions against the risk of fire in the designated and in particular, in relation to the arrangements for containing fire. Many of the fire safety deficits had been raised on a previous inspection. Where there had been some improvements there remained a considerable number of important works outstanding, for example fire containment measures throughout the centre. As a result, this meant that there was an ongoing and continuous risk to residents' safety in the centre.

While there had been some improvement to the house, including the installation of a wet room, interim works to exits from the back of the house and a new external seating area overall, the planned renovation to provide a more homely and accessible environment for residents had not gone ahead as planned.

There had also been some maintenance work completed on areas of the house to better ensure the effectiveness of the infection prevention control measures in place. However, outstanding upkeep and repair to doors, door frames, and facilities,

meant that there was an on-going and continued risk to residents' safety in terms of the spread of healthcare-associated infection.

Improvements were needed to the arrangements in place for the provision of positive behavioural supports. The inspector found that there had been an increase in behaviours of concern for a number of residents however, the timeliness to provide them with appropriate supports was not adequate. This meant that there was an on-going risk of behaviours of concern continuing and in turn, resulting in negative outcomes for residents.

Staff were provided with training to enable them keep residents' safeguarded. Safeguarding measures were in place to ensure that staff providing personal intimate care to residents, who required such assistance, did so in line with each resident's personal plan and in a manner that respected each resident's dignity and bodily integrity.

For the most part, safeguarding concerns were appropriately followed up and included preliminary screenings, safeguarding plans, investigations and notification to the appropriate services. Where safeguarding plans were put in place, this was to mitigate the risk of the concern arising again and to ensure residents were appropriately supported so that they felt safe in their own home. However, improvements were needed to ensure that where safeguarding supports were recommended, that they were effective and timely.

The inspector found that the designated centre was not being operated, managed or resourced in a way that was fully respectful of residents needs and rights. Residents rights relating to their privacy, dignity, safety and independence were not being promoted at all times.

Regulation 17: Premises

Actions previously committed to by provider had not all been completed or completed as per assurances submitted to HIQA. Since the last inspection, a new wet room was installed downstairs and interim works to improve access to back of house and laundry room were put in place. Lottery funding secured saw a new seating area with a pergola and raised planters out the back of the house. However, other planned works to the kitchen, sitting room and upstairs bathrooms, for example, had not been carried out and there was no plan in place or timeline to complete the work.

Interim measures to better promote accessibility, were not in line with the 2018 and 2022 recommendations from an allied healthcare professional. For example, where a ramp from one of the back doors out to the garden and laundry room was recommended, interim measures such as, raised step, hand-rails and yellow paint on steps were implemented instead.

The provider submitted an update to HIQA in August 2023 that there was a plan in

place to move residents to an alternative location while a schedule of major renovations to the premises and fires safety works were to be carried out in January 2024. It was anticipated by the provider at that time, that the project would be completed in August 2024. However, this plan did not come to fruition and the major renovations, as well as a significant aspect of the fire safety works, had not gone ahead as planned.

Overall, the inspector found that the poor state of upkeep and repair of the premises was impacting on the accessibility needs of residents, the quality of their environment and could not promote optimum implementation of infection prevention and control standards and precautions. The provider had not taken sufficient action to complete recommended works that would better promote residents' independence and accessibility in their home.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector reviewed the centre's risk management policy and found that the provider had ensured that the policy met the requirements as set out in the regulations.

There was a risk register specific to the centre that was reviewed regularly. There was an array of individual and location risk assessments in place to ensure the safe care and support was provided to residents.

The person in charge had completed a range of risk assessments, which for many included appropriate control measures, that were specific to the resident's individual health, behavioural and personal support needs but to mention a few.

However, while the provided had identified the risks posed by the fire safety deficits in the designated centre, the control measures in place were not adequate in ensuring the safety of all residents in the event of a fire. This has been primarily addressed in regulation 28.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Despite a number of interim upkeep and repair works completed through-out the house overall, the provider had not ensured that the previous inspection’s compliance plan actions relating to the protection against infection, were completed or within the timeframe stated. This meant that there were a number of facilities and areas in the house that were in poor upkeep and repair. These deficits meant

that there was a continued to pose a risk of the spread of healthcare-associated infection and overall, impact on the health and safety of residents.

A walk-around of the centre demonstrated that while the premises was generally clean and tidy, not all areas of the premises were conducive to a safe and hygienic environment. For example,

Doors, doorframes and door saddles through-out the house were observed to be in poor upkeep, including scuffing and chipped paint.

The flooring on a resident's bedroom floor was badly scrapped which meant that it could not be effectively cleaned.

A wardrobe in a resident's bedroom room was observed to have chipped timber.

An upstairs bathroom, which was due to be changed into a wet room, remained the same; There was a plastic fan inserted into the middle of a round window, which was observed to have a heavy build-up of dirt on it. Bath tiles were observed to have dark grime on the grout, and clear contact on the window was worn, peeling off and unclean.

While there had been cleaning checklists implemented for residents' mobility equipment since the last inspection, this had not been put in place for all equipment. For example, an assisstive aid in the upstairs bathroom, (bath-chair), was observed to be unclean. The inspector was informed that the chair was not on the cleaning list and was not being cleaned as per the equipment's manufacturer's instructions.

The kitchen skirting was observed to be chipped through-out and the radiator was rusty in areas. Where there were plans to upgrade the floor, due to its poor state of repair, an interim measure of a new patch of flooring had been installed instead.

The sink and draining board in the external laundry room was observed as stained and unclean. This had been raised on a previous inspection of the centre.

Where a door saddle was removed from a resident's downstairs bedroom floor to provide ease of access, there was a gap in the flooring which meant it was likely to trap dirt and present as difficult to clean.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had not ensured comprehensive fire safety management systems were in place at all times;

Information available from an external fire safety consultant in May 2021 and separately from a fire door inspection proposal (sent to the provider in April 2024),

as well as previous HIQA inspections, identified that there were deficits in relation to fire containment in the designated centre. A number of recommended actions to address these deficits remained outstanding.

The May 2021 external fire safety assessment saw a number of recommendations risk rated red which needed to be completed within six months of the report findings, other recommendations were orange risk rated which needed to be carried out within six to twelve months with the remainder of the recommendations to be carried within 24 months. On the day of the inspection, a number of recommendations remained outstanding and in particular, improvements required to fire doors and frames. While the provider had organised for a further assessment of fire doors in the house in 2024, other issues that had been identified on the May 2021 report, had not been addressed. For example, the integrity of a number of walls and ceilings which had been highlighted in relation to their fire resistant capacity.

The April 2024 external fire door inspection proposal recommended the replacement and removal of 20 existing doors and frames; The inspector was informed by senior management that it would take 12 – 16 weeks to replace the required fire doors. However, the inspection (and previous inspections), found that provider had no satisfactory timeframe or plan for addressing the recommendations. Overall, this did not provide an assurance that the provider was putting in place responsive action to address fire safety deficits in the centre.

The inspection also found that the provider had not ensured suitable arrangements, for staff to be aware of their role and responsibility, should a fire break out in the in the designated centre. For example, there was no system or arrangements in place, on a daily basis, that identified a staff member to take responsibility of coordinating and leading an evacuation should a fire break out.

The provider submitted assurances that their maintenance team would complete a course in fire door maintenance in March 2024 that would support them in carrying out inspections and general repair of the centre's fire doors. However, as of the day of inspection, the training remained outstanding.

The half-door at the top of a fire escape stairwell had not been addressed as per the previous inspection's compliance plan action. For example, the door had not been replaced with a half metal door that would readily open when pushed. A lock remained on the door, which required reaching through a hole to open the lock. This meant that the door continued to potentially impacted on optimal ease of evacuation for residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Improvements were needed to the provision of positive behavioural supports so that

arrangements were in place to support and respond to residents' assessed support needs.

On speaking with the person in charge and a review of behavioural incidents, the inspector saw that there had been an increase in issues of concern for a number of residents living in the centre. In addition the provider's own auditing system (six monthly unannounced review), identified that there was an increase in occurrences of issues of concern for three residents during the periods 05/03/2023 to 05/03/2024.

For one resident, the increase saw an increase of eight to fifteen issues of concern which primarily related to an increase in anxiety and self-harm. For another resident there was an increase from ten to twenty eight issues of concerns. There was a risk assessment in place regarding the type of behaviours the resident was presenting with and one of the control measures included a positive behavioural support plan. While, there were support plans in place for one resident, the plans were not developed or provided oversight by an appropriate allied healthcare professional or clinician.

On review of a sample of residents' personal plans and speaking with the person in charge, the inspector saw that a referral for positive behavioural supports had been made for one resident in June 2023 however, there was no further update on the plan or timelines for the plan since then. For another resident, it was unclear as to the date of their referral but the inspector was informed that it was pre-2022.

This meant that residents were not provided with satisfactory supports to help them manage their behaviours and as such, it was likely that there was a risk of behavioural incidents continuing and overall, having a negative impacts on the health and wellbeing of residents.

This also meant that staff were not provided with satisfactory plans and/or strategies in supporting them appropriately and safely respond to any behaviours of concern.

There were a small number of restrictive practices in place in the centre. For example, there was a restriction regarding access to internet usage and a restriction relating to the management of residents' monies. While these had been identified and were included on the provider's restrictive practice register, they had not been appropriately notified to HIQA as required.

Judgment: Not compliant

Regulation 8: Protection

The inspector found that supports provided to residents subsequent to three safeguarding incidents, did not provide assurances of their effectiveness. Within three months (December 2023 and March 2024) there had been two safeguarding

concerns that had a significant negative impact on the wellbeing of a number of residents living in the house. Notifications reviewed, relayed that residents were frightened during and after the alleged incidents.

A review of safeguarding plans, preliminary screening forms and audits relating to issues of concern, demonstrated an increase in anxiety and behaviours of concern for residents impacted. The documents relayed that residents' were concerned for their safety and were anxious of a similar situations arising again. It was also noted that residents were displaying behaviours of concern such as, an increases in anxiety, self-harm incidents and not sleeping.

Previous to the two above safeguarding incidents, another safeguarding concern was raised in September 2022. An update on the investigation submitted to HIQA in January 2023 showed that over that period, the resident remained anxious of the outcome and in particular, the uncertainty of future staffing arrangements in their home.

Follow-up information requested by HIQA included assurances that therapeutic interventions would be put in place for all residents by the end of January 2024. In addition, on review of interim safeguarding plan actions, the inspector saw that specific mental health training for staff was included as one of the actions. Other actions included staff providing one to one support discussions with residents.

However, on the day of the inspection, the inspector was informed that staff had not yet been provided the training and there was no plan or timeline in place for the training to be competed. This meant that the provider could not be assured that staff had the appropriate skills and knowledge to support residents with any mental health or wellbeing issues they may of had or the effectiveness of any support discussions that took place. In addition, while, therapeutic interventions such as wellbeing and massage therapies, as well as in-house counselling sessions were offered to residents, this was for a brief period of time, with residents paying for the services after March 2024.

The inspector found that a review of the actions and support systems in place, following staff related safeguarding concerns, was needed. This was to ensure that actions required were fully implemented in a timely manner and that supports put in place were effective in making residents feel safe. Overall, the inspector found that until all actions and supports had proved effective, residents' wellbeing remained at risk with a likelihood of continued anxieties.

Judgment: Not compliant

Regulation 9: Residents' rights

The centre was not being operated in a manner that was respectful of all residents' needs and rights.

Not all residents' right to feel safe in the their home was promoted; residents felt anxious and unsafe for a number of reasons. The inspector found that the supports put in place for residents subsequent to safeguarding incidents had not always been effective.

Not all residents' right to be provided with appropriate facilities that supported their independence was promoted. In addition, not all residents' privacy and dignity in relation to their intimate and personal care were promoted. Sufficient shower facilities and adequate ramp facilities, that would enhance residents' independence, had not been installed as previously planned or in line with allied healthcare professionals' recommendations .

Not all residents' right to live in a home that provided the optimum homely and safe environment was promoted. Residents were living in a house were fire containment measures were not effective. In addition, residents were living in a home where there was poor upkeep and repair to areas and facilities that overall, negatively impacted on infection, prevention control measures and increased the risk of spread of healthcare-associated infections.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Bellavista OSV-0001701

Inspection ID: MON-0034029

Date of inspection: 23/05/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Bespoke recruitment review which includes reduction of part time staff is ongoing and reviewed weekly. Additionally, the current cohort of staff on part-time contracts were approached and 2 staff members have accepted 150-hour contracts which will ensure better continuity of care. 1 staff member has accepted 169-hour contract, reducing the vacancies one 100 hour contract and one 130 hour day service contract. The number of staff on part-time staff will be further reduced by the end of October 2024.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff in the designated centre have completed an online mental health course, "looking after mental health" course has also been completed and mental health psychiatric disorders online course in April 2024. Further training on mental health, focusing on depression and anxiety will be completed by all staff by the 15th of August 2024.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
In relation to the outstanding works:

These are the works highlighted in previous inspections:

• Gaps at edge of whiterock behind toilet upstairs have been fixed-Completed

• Flooring downstairs: To be completed by 30.8.24
• Grouting under sink and around sink: This was stained so it was removed and replaced- Complete.
• The whiterock finish was rectified. Completed
• Fire doors - Business case for replacing 21 fire doors submitted 22.04.24.
• Replacement of 4 doors , 2 x kitchen 2 x living room . Completed
• Wet room downstairs. Completed
• External emergency lighting. Completed.
• Raised steps at the back door from kitchen to the garden, instead of ramp, with hand rails at either side as advised by OT and Physiotherapist's report. Completed
• Replaced attic hatch with fire rated board and installed fire rated door at hot press. Completed.
• Electrical panel in bedroom deactivated and replaced with a panel in the corridor. Completed.
• Installation of sensor lights in hallways. Completed

The provider has reviewed the suitability of the designated center in relation to t the changing needs and compatibility challenges of the residents and has engaged with the funder's DE congregation team to further progress relocation of residents to suitable property. The compatibility assessments will be completed by 31st August 2024. The PIC is currently supporting the residents to apply for social housing via the local County Council. The provider is also sourcing potential suitable locations in the local.

The provider is currently drafting an associated business case for related costs to the funder for CAS funding and appropriate resourcing to facilitate de-congregation of the designated center.

The PIC and PPIM have agreed on a communication plan, which includes a FAQ in accessible form on moving home for the residents. The communication plan will be completed by the 30th of July 2024.

When residents move location a robust transition plan will be completed for each resident in line with their communication style and individual care and support needs.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
In line with the Provider Governance / Management Plan 2024, the provider is implementing a Quality Assurance Framework commencing week beginning 12th August. The Provider has reviewed and enhanced reminders which are in place for PICs of services to complete quarterly notifications in a timely manner.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Raised steps at the back door from kitchen to the garden, instead of ramp, with hand rails at either side as advised by OT and Physiotherapist's report. Completed

Current doors, frame and saddle board in poor upkeep to be completed 09.07.2024
Wardrobe timber chipped to be completed 09.07.2024
Front bathroom dirty plaster fan – To be completed by 30.8.24
Front bathroom dirty tiles and grout to be completed 10.07.2024
Front bathroom clear contact peeling – To be complete by 30.8.24
Shower chair cleaning on check list 24.06.2024
Sink and draining board in external laundry room dirty and stained – Whiterock to be completed 11.07.2024
Saddle board removed at bedroom gap in floor – To be completed by 30.8.24
Maintenance Fire Door Training – External contractor will carry out bi-annual fire door inspections
Automatic metal door top of stairs – External fire consultant have advised to install a fire door. This is part of the business case submitted to the funders.

The provider has reviewed the suitability of the designated center in relation to t the changing needs and compatibility challenges of the residents. and has engaged with the funder's De-congregation team to further progress relocation of residents to suitable property. The compatibility assessments will be completed by 31st of August 2024. The provider is currently supporting the residents to apply for social housing via the local County Council. The provider is also sourcing potential suitable locations in the local.

The provider is currently drafting an associated business case for related costs to the funder for CAS funding and appropriate resourcing to facilitate de-congregation of the designated center.

The PIC and PPIM have designed a communication plan, which includes a FAQ in accessible form on moving home for the residents. The communication plan will be completed by the 30th of July 2024.

When residents move location a robust transition plan will be completed for each resident in line with their communication style and individual care and support needs

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risks relation to fire safety have been addressed as follows:

A business case to fund the installation of the required fire doors in the location was submitted on the 22/04/2024. The following measures have been put in place in the meantime to mitigate risks within the service:

• Staff within Bellavista have completed Fire Safety Training and are made aware of the fire evacuation procedure on induction. This is available both at the front door and within the Bellavista folder.
• Agency staff working on location also have this available in the Agency Induction folder and are directed to this on induction.
• All staff are trained and up to date in fire safety training.
• Local management has conducted location specific fire safety information sessions onsite for all staff beginning on the 03.06.2024. All staff will have completed this information session by the 01/07/2024. This will ensure that staff, including regular agency, are aware of the fire safety protocols and their role within fire safety in the designated centre, such as assembly points, extinguishers, exits and evacuation protocol.
• One sleepover staff in the centre has been converted to a waking night to improve identification and reaction times in case of a fire. 1 sleepover and 2 waking night staff in place.

• Two evac chair have been ordered on the 20th of June 2024 to support residents with mobility issues during evacuation. Training will be provided to staff team 23rd July 2024.

• Day and night fire evacuation simulation have been completed with new staffing levels.

• Day and night fire evacuation simulation will be completed with two evac chairs by the

30th of July 2024.

• PEEPS have been updated to reflect increase in staffing arrangements, and this is part of the location specific fire safety sessions.
• PEEP will be updated to include the use of fire evacuation chairs by the 30th of July 2024.
• Fire evacuation simulations are completed twice monthly.
• Daily fire checks are completed by staff. 28/05/2024
• Twice daily exit checks in place. 28/05/2024
• Daily door guard closure checks are in place. 28/05/2024
• Door closures are tested daily to ensure doors close fully. 28/05/2024.

The Integrated Risk Management policy and procedure has been updated and disseminated as has the Terms of Reference for the Quality and Risk Monitoring Committee, which is Trustee Led.
An organisational Governance Management Plan 2024 has been implemented. This contains a Quality Assurance framework and will include related training, implementation is scheduled for August 2024.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Current doors, frame and saddle board in poor upkeep to be completed 09.07.2024
Wardrobe timber chipped to be completed 09.07.2024
Front bathroom dirty plaster fan – To be completed by 30.8.24
Front bathroom dirty tiles and grout to be completed 10.07.2024
Front bathroom clear contact peeling – To be completed by 30.8.24
Shower chair cleaning on check list 24.06.2024
Sink and draining board in external laundry room dirty and stained – Whiterock to be completed 11.07.2024
Saddle board removed at bedroom gap in floor - To be completed by 30.8.24
Maintenance Fire Door Training – External contractor will carry out bi-annual fire door inspections
Automatic metal door top of stairs – External fire consultant have advised to install a fire door. This is part of the business case submitted to the funders.
On review of suitability of the designated center in relation to the maintenance of the property and changing needs of the clients the funder's de-congregation team has been consulted with by the provider for consideration regarding the de-congregation funding / relocation to smaller properties that meets the residents' needs.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: An external contractor is now engaged to complete bi-annual fire door inspections in lieu of inhouse training. Completed.

Risks relation to fire safety have been addressed as follows:

A business case to fund the installation of the required fire doors in the location was submitted on the 22/04/2024. The following measures have been put in place in the meantime to mitigate risks within the service:

• Staff within Bellavista have completed Fire Safety Training and are made aware of the fire evacuation procedure on induction. This is available both at the front door and within the Bellavista folder.
• Agency staff working on location also have this available in the Agency Induction folder and are directed to this on induction.
• All staff are trained and up to date in fire safety training.
• Local management has conducted location specific fire safety information sessions onsite for all staff beginning on the 03.06.2024. All staff will have completed this information session by the 01/07/2024. This will ensure that staff, including regular agency, are aware of the fire safety protocols and their role within fire safety in the designated centre, such as assembly points, extinguishers, exits and evacuation protocol.
• One sleepover staff in the centre has been converted to a waking night to improve identification and reaction times in case of a fire. 1 sleepover and 2 waking night staff in place.

• Two evac chair have been ordered on the 20th of June 2024 to support residents with mobility issues during evacuation. Training will be provided to staff team 23rd July 2024.

• Day and night fire evacuation simulation have been completed with new staffing levels.

• Day and night fire evacuation simulation will be completed with two evac chairs by the 30th of July 2024.

• PEEPS have been updated to reflect increase in staffing arrangements, and this is part of the location specific fire safety sessions.
• PEEP will be updated to include the use of fire evacuation chairs by the 30th of July 2024.
• Fire evacuation simulations are completed twice monthly.
• Daily fire checks are completed by staff. 28/05/2024
• Twice daily exit checks in place. 28/05/2024
• Daily door guard closure checks are in place. 28/05/2024
• Door closures are tested daily to ensure doors close fully. 28/05/2024.

The provider has reviewed the suitability of the designated center in relation to t the changing needs and compatibility challenges of the residents, and has engaged with the funder's de- congregation team to further progress relocation of residents to suitable property. The compatibility assessments will be completed by 31st of August 2024. The provider is currently supporting the residents to apply for social housing via the local County Council. The provider is also sourcing potential suitable locations in the local.

The provider is currently drafting an associated business case for related costs to the funder for CAS funding and appropriate resourcing to facilitate de-congregation of the designated center.

The PIC and PPIM have agreed on a communication plan, which includes a FAQ in accessible form on moving home for the residents. The communication plan will be completed by the 30th of July 2024.

When residents move location a robust transition plan will be completed for each resident in line with their communication style and individual care and support needs

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
In line with the Provider Governance / Management Plan 2024, the provider is implementing a Quality Assurance Framework commencing week beginning 12th August. The Provider has reviewed and enhanced reminders which are in place for PICs of services to complete quarterly notifications in a timely manner without omissions.

The Provider is implementing a behavior support strategy including:
A Human Rights based Positive Behavior Policy has been approved and is under implementation July 2024.
This will include organisational wide training for staff to promote the further mitigation of risks relating to behaviors that challenge. This is expected to be completed for the designated centre by 31/08/2024.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

2 residents had availed of counselling sessions following safeguarding incidents. These residents decided to end sessions after a period of time. A third resident did not agree to partake in counselling.

The provider has reviewed the suitability of the designated center in relation to t the changing needs and compatibility challenges of the residents. and has engaged with the funder's De-congregation team to further progress relocation of residents to suitable property. The compatibility assessments will be completed by 31st August 2024. The provider is currently supporting the residents to apply for social housing via the local County Council. The provider is also sourcing potential suitable locations in the local.

The provider is currently drafting an associated business case for related costs to the funder for CAS funding and appropriate resourcing to facilitate de-congregation of the designated center.

The Provider's Safeguarding Policy has been updated and approved on 2nd July 2024. An implementation Plan has been approved a new role of safeguarding liaison officer, under recruitment, to provide a more robust level of guidance and support within the organisation.
A Special Interest Group on safeguarding has been establishes with the following initial objectives:
• To develop quality initiatives in relation to adult protection and capability.
• To implement quality initiatives including an "Awareness Program".
The inaugural meeting is scheduled in July.

All staff in the designated center have completed an online mental health course, "looking after mental health" course has also been completed and mental health psychiatric disorders online course in April 2024.

Further training on mental health, focusing on depression and anxiety will be completed by all staff by the 15th of August.

The Provider is implementing a behavior support strategy including:
A Human Rights based Positive Behavior Policy has been reviewed and is awaiting final approval expected approval date July 2024.
Following the release of the above policy a further implementation plan includes organizational wide training for staff to promote the further mitigation of risks relating to behaviors that challenge. This is expected to be completed for for this designated

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
2 residents had availed of counselling sessions following safeguarding incidents. These residents decided to end sessions a period of time. A third resident did not agree to

partake in counselling.

All staff in the designated centre have completed an online mental health course, "looking after mental health" course has also been completed and mental health psychiatric disorders online course in April 2024.

Further training on mental health, focusing on depression and anxiety will be completed by all staff by the 15th of August 2024.

The provider has reviewed the suitability of the designated center in relation to t the changing needs and compatibility challenges of the residents and has engaged with the funder's de-congregation team to further progress relocation of residents to suitable property. The compatibility assessments will be completed by 31st August 2024. The provider is currently supporting the residents to apply for social housing via the local county council. The provider is also sourcing potential suitable locations in the local.

The provider is currently drafting an associated business case for related costs to the funder for CAS funding and appropriate resourcing to facilitate de-congregation of the designated center.

The PIC and PPIM have agreed on a communication plan, which includes a FAQ in accessible form on moving home for the residents. The communication plan will be completed by the 30th of July 2024.

When residents move location a robust transition plan will be completed for each resident in line with their communication style and individual care and support needs

The Provider is implementing a behavior support strategy including:
A Human Rights based Positive Behavior Policy has been reviewed and is currently under dissemination (July 2024)
The implementation plan includes organisational wide training for staff to promote the further mitigation of risks relating to behaviors that challenge. This is expected to be completed by Q4 2024.
The Provider's Safeguarding Policy has been updated and approved on 2nd July 2024. An implementation Plan has been approved a new role of safeguarding liaison officer, under recruitment, to provide a more robust level of guidance and support within the organisation.
A Special Interest Group on safeguarding has been establishes with the following initial objectives:
• To develop quality initiatives in relation to adult protection and capability.
• To implement quality initiatives including an "Awareness Program".
The inaugural meeting is scheduled in July.

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/10/2024
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.	Not Compliant	Orange	31/10/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	15/08/2024

	training, including refresher training, as part of a continuous professional development programme.			
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.	Not Compliant	Orange	31/08/2024
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	31/08/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/08/2024
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/07/2025

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate 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	31/12/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/08/2024
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all	Not Compliant	Orange	31/12/2024

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/12/2024
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.	Not Compliant	Orange	01/07/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	12/09/2024
Regulation 07(1)	The person in	Not Compliant	Orange	31/08/2024

	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.			
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	31/08/2024
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	31/08/2024
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under	Substantially Compliant	Yellow	31/08/2024

	this Regulation the least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Not Compliant	Orange	30/07/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/07/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/12/2024