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:	Appleview
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	11 April 2024
Centre ID:	OSV-0001702
Fieldwork ID:	MON-0034206

About the designated centre

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

Appleview is a designated centre operated by Sunbeam House Services CLG, located in an urban area of County Wicklow. The designated centre offers residential services to four male adults with intellectual disabilities. The designated centre consists of a detached house which is located in a housing estate and consists of a sitting room, dining room, kitchen, utility room, four individual bedrooms, a staff sleepover room, an office and a number of shared bathrooms. The house provides residents with a garden space to the rear of the property. The centre is staffed by a person in charge and social care workers. The person in charge works in a full-time capacity and they are also responsible for a separate designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 11 April 2024	08:45hrs to 16:45hrs	Kieran McCullagh	Lead

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre.

The inspection was facilitated by the person in charge for the duration of the inspection. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff, to form judgments on the residents' quality of life. The inspector found that the person in charge and staff were striving to ensure that residents living in the designated centre were supported to enjoy a good quality life and to make choices and decisions about their care. However, some aspects of the service provision were impacted upon due to risks relating to positive behavioural support and safeguarding, which required the provider to put in place effective and suitable measures in order to mitigate and manage those risks.

The designated centre is situated in a coastal town in County Wicklow. The house comprised of five bedrooms, including one staff sleepover room, kitchen, dining room, sitting room, utility room and three bathrooms. The centre is registered to accommodate four people and the inspector had the opportunity to meet all four residents over the course of the inspection.

The residents had been made aware of the upcoming inspection, gave the inspector a warm welcome and were very comfortable with the presence of the inspector in their home. Throughout the inspection the inspector saw residents being supported to participate in a variety of home and community based activities, which included residents being supported by staff to get haircuts, shopping, going to the gym and independent living skills, such as preparing breakfast and making tea and coffee.

Residents said that they were happy with the service. They told the inspector they liked their bedrooms and the layout and décor of their home. Throughout the inspection, residents were seen to be at ease and comfortable in the company of staff, and were observed to be relaxed and happy in their home. It was clear during the inspection that there was a good rapport between residents and staff.

One resident spoken with, told the inspector they "didn't get along" with some residents and staff saying this was the result of a "personality clash". However, the resident also said they liked living in their home and enjoyed the food in the centre. They spoke about things they liked and about the television programmes they liked to watch.

The person in charge described the quality and safety of the service provided in the centre as being very personalised to the residents' individual needs and wishes. They spoke about the high standard of care all residents receive. In addition, they spoke about the challenges in relation to compatibility issues. The inspector found

that overall, the person in charge and staff team were striving to ensure that residents' well-being and welfare was maintained to a good standard. The residents were encouraged and supported to live independent lives in line with their will and preference. However, this inspection found there were improvements required in relation to the implementation of National safeguarding policies and procedures, this is further discussed later in the report.

Staff spoke to the inspector regarding the residents' assessed needs and described training that they had received to be able to support such needs, including communication, feeding, eating, drinking and swallowing (FEDS), safeguarding, medication management and managing behaviour that is challenging. The inspector found that the staff members on duty were very knowledgeable of residents' needs and the supports in place to meet those needs. Staff were aware of each resident's likes and dislikes.

The inspector carried out a walk around of the centre in the presence of the person in charge. The premises was observed to be clean and tidy and was decorated with residents' personal items such as photographs and artwork. Residents' bedrooms were laid out in a way that was personal to them and included items that was of interest to them. To the rear of the centre, was a well-maintained garden area, that provided outdoor seating for residents to use, as they wished.

Residents had completed resident questionnaires prior to the inspection and the person in charge provided copies of each resident's questionnaire to the inspector for review. Some residents provided positive feedback in relation to the food, bedrooms, activities and staff team. Other residents commented on not getting on with other residents and staff, wanting to cook more and wanting to live independently.

From speaking with residents and observing their interactions with staff, it was evident that they felt very much at home in the centre, and were able to live their lives and pursue their interests as they chose.

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

This section of the report sets out the findings of the inspection in relation to the overall delivery of the service and how the provider was ensuring that a good-quality, safe and effective service was provided to residents. The registered provider had implemented management systems to monitor the quality and safety of service provided to residents. However, increased oversight was required, in particular areas such as notification of incidents, positive behavioural support and safeguarding

which is further discussed in the quality and safety section of the report.

The inspector observed a clearly defined management structure in place. Staff demonstrated that they were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, who was knowledgeable about the support needs of the residents living in the centre. The person in charge was worked full-time and was responsible for this and another designated centre. They were present in this centre regularly and they were supported in their role by a senior service manager.

The provider completed an annual review of the quality and safety of care and support in the centre and identified areas for ongoing improvement. A six-monthly unannounced visit of the centre had taken place in February 2024. Subsequently, there was an action plan in place to address any concerns regarding the standard of care and support provided.

As previously mentioned, additional governance and management arrangements were required to ensure the person in charge was submitting notifications to the Chief Inspector of Social Services, as per the regulations. In addition, further oversight arrangements were required regarding positive behavioural supports and safeguarding, which were negatively impacting on residents lived experiences.

The provider ensured that there were suitably qualified, competent and experienced staff on duty to meet residents' current assessed needs. The inspector observed that the number and skill-mix of staff contributed to positive outcomes for residents using the service. For example, the inspector saw residents being supported to participate in a variety of home and community based activities of their own choosing. Warm, kind and caring interactions were observed between residents and staff. Staff were observed to be available to residents should they require any support and to make choices.

The education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. A supervision schedule and supervision records of all staff were maintained in the designated centre. The inspector saw that staff were in receipt of regular, quality supervision, which covered topics relevant to service provision and professional development.

The provider had systems in place to ensure records, as required by the regulations, were of good quality and were accurate, up-to-date and stored securely.

The registered provider had prepared a written statement of purpose that contained the information set out in Schedule 1. The statement of purpose clearly described what the service does, who the service is for and information about how and where the service is delivered. In addition, the statement of purpose was available to residents and their representatives in a format appropriate to their communication needs and preferences.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the regulations.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the skill-mix and staffing levels allocated to the centre were in accordance with the resident's current assessed needs. Staffing levels were in line with the centre's statement of purpose and the needs of its residents.

The inspector reviewed both the planned and actual rosters and found that these reflected the staffing arrangements in the centre, including staff on duty during both day and night shifts.

There was one whole-time-equivalent staff vacancy at the time of inspection and recruitment was underway to back fill this. From a review of planned and actual rosters the inspector found evidence that this vacancy was managed by a small panel of familiar relief and one regular agency staff, which ensured continuity of care and support for residents.

The inspector observed staff engaging with residents in a respectful and warm manner, and it was clear that they had a good rapport and understanding of the residents' needs.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the centre's staff training records. Staff in the centre had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support residents. These included training in mandatory areas such as fire safety, managing behaviour that is challenging and safeguarding of vulnerable adults.

In addition, training was provided in areas such as feeding, eating, drinking and swallowing (FEDS), first aid and safe administration of medication.

The inspector found that staff were receiving regular supervision as appropriate to their role and, the person in charge had developed a schedule of supervision for

2024 for all staff members. Supervision records reviewed were in line with organisation policy and included a review of the staff members' personal development and provided an opportunity for them to raise any concerns.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured information and documentation on matters set out in Schedule 2 were maintained and were made available for the inspector to view.

The inspector reviewed four staff records and found that they contained all the required information in line with Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place which included the person in charge and the senior services manager for the organisation. There were arrangements for the management team to communicate and escalate issues.

The provider had implemented systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. For example, the inspector reviewed the most recent six-monthly unannounced visit to the centre and found that action plans were developed to address any issues identified. In addition, a suite of audits were in place including infection, prevention and control, health and safety and medication management.

An annual review of the quality and safety of care had been completed for 2023. However, there was no written evidence to document consultation with family members or resident's representatives in the annual review. This required review by the provider.

During the course of the inspection, the inspector observed that increased oversight was required, in particular areas such as notification of incidents, positive behavioural support and safeguarding. These findings are further reflected in the report under Regulations 31, 7 and 8.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which accurately outlined the service provided and met the requirements of the regulations.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre.

In addition, a walk around of the property confirmed that the statement of purpose accurately described the facilities available including room size and function.

Judgment: Compliant

Regulation 31: Notification of incidents

Prior to and during the course of the inspection the inspector completed a review of notifications submitted to the Chief Inspector and found that the person in charge did not notify the Office of the Chief Inspector in writing of the occurrence of the events set out in Regulation 31(3) on a quarterly basis. For example, the person in charge did not notify the Chief Inspector of the following events in Quarter 1, 2 and 3 of 2023:

- Any occasion where a restrictive procedure including physical, chemical or environmental restraint was used.
- Any injury to a resident that did not require notification within three working days (i.e. not 'serious injury').

For example, there were 2 restrictive practices in use and a number of noticeable injuries that had not been notified to the Office of the Chief Inspector.

In addition, the person in charge submitted an incorrect six-monthly nil return for events that require notification on a quarterly basis.

This requires review and improvement in order to assure the Office of the Chief Inspector that any risk to the quality and safety of care and support has been or is being addressed.

Judgment: Not compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre.

This inspection found that the provider and person in charge were operating the centre in a manner that supported residents to receive a service that was person-centred. However, as previously stated improvements were required in relation to positive behavioural support and safeguarding.

The inspector completed a walk around of the centre with the person in charge. The design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. The provider ensured that the premises, both internally and externally, was of sound construction and kept in good repair. There was adequate private and communal spaces and residents had their own bedrooms, which were decorated in line with their taste and preferences.

The inspector observed that the provider was adhering to National Standards for Infection prevention and control in community services (2018) and that all residents, staff and visitors were protected from the risk of infection. Good practice in relation to infection prevention and control was observed by the inspector throughout the course of the inspection. There were adequate hand hygiene facilities in the centre. Cleaning checklists showed that the centre was cleaned in line with the provider's guidelines. Staff were observed adhering to infection control measures, which ensured that care was provided to residents in a clean and safe environment.

The provider had mitigated against the risk of fire by implementing suitable fire prevention and oversight measures. There were suitable arrangements in place to detect, contain and extinguish fires in the centre. There was documentary evidence of servicing of equipment in line with the requirements of the regulations. Residents' personal emergency evacuation plans were reviewed regularly to ensure their specific support needs were met.

Some residents required support to manage their behaviours of concern. However, positive behaviour support plans had not been prepared for residents who had assessed behavioural support needs. The provider had not used positive behavioural supports to reduce the risk of behaviours of concern from occurring.

The provider's safeguarding policy and supporting procedures did not comprehensively reflect National Safeguarding of Vulnerable Adults guidelines. The inspector observed poor safeguarding practices in the designated centre, which included the provider's systems for the reporting of safeguarding concerns.

Regulation 17: Premises

The inspector carried out a walk around of the centre in the presence of the person in charge, which confirmed that the premises was laid out to meet the assessed

needs of the residents.

Each resident had their own bedroom which was decorated to their individual style and preference. For example, residents' bedrooms included family photographs, pictures and memorabilia that were in line with the residents' preferences and interests. This promoted the residents' independence and dignity, and recognised their individuality and personal preferences.

Since the last inspection, there had been some home improvements works completed to the centre, which resulted in positive outcomes for residents. For example, kitchen upgrade works which provided residents with better and more accessible facilities.

Residents had access to facilities which were maintained in good working order. There was adequate private and communal space for them as well as suitable storage facilities and the centre was found to be comfortable, homely and overall in good structural and decorative condition.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents with assessed needs in the area of feeding, eating, drinking and swallowing (FEDS) had up-to-date FEDS care plans on file and there was guidance regarding their meal-time requirements including food consistency and residents' likes and dislikes.

Staff spoken with were knowledgeable regarding FEDS care plans and were observed to adhere to the directions from specialist services such as speech and language therapy, including advice on therapeutic and modified consistency dietary requirements. The inspector had the opportunity to observe some mealtime experiences for residents, including breakfast and lunchtime meals. Residents were provided with wholesome and nutritious food, which was in line with their assessed needs.

Residents had opportunities to be involved in food preparation in line with their wishes and the inspector observed one resident being supported by staff to make their own fruit smoothie. The inspector observed suitable facilities to store food hygienically and adequate quantities of food and drinks available in the centre. The fridge and presses were stocked with lots of different food items, including fruit and vegetables.

Residents spoken with confirmed that they felt they had choice at mealtimes and that they had access to meals, refreshments and snacks at all reasonable hours.

Judgment: Compliant

Regulation 27: Protection against infection

Appropriate infection prevention and control (IPC) practices were in place. All current public health guidance was being followed. Monthly health and safety audits were complete in the centre and in addition an external IPC audit was undertaken in 2023. The inspector reviewed this audit and found that actions identified were complete.

The centre was observed to be clean and appropriate hand washing and hand sanitisation facilities were available to staff, residents and visitors. The centre was well maintained and appropriate control measures, such as the appropriate use of PPE, were in place to reduce the probability of residents being exposed to infectious agents.

Cleaning schedules were in place and reviewed by the inspector, which evidenced that cleaning was being done daily. Records provided also indicated that all staff had completed relevant training in infection prevention and control.

There were systems in place for the management of laundry and body fluid spillage. Staff spoken with were aware of these systems and procedures to follow.

The inspector observed that colour coded mops and buckets were stored in a clean dry area and the registered provider had systems in place for the management of waste.

Judgment: Compliant

Regulation 28: Fire precautions

The centre had appropriate and suitable fire management systems in place which included containment measures, fire and smoke detection systems, emergency lighting and fire fighting equipment. The inspector reviewed servicing records and found that these were all subject to regular checks and servicing with a fire specialist company.

The fire panel was easily addressable and there was guidance displayed beside it on the different fire zones in the centre. The inspector observed that all fire doors, including bedroom doors closed properly when the fire alarm was activated.

The person in charge had prepared evacuation plans to be followed in the event of the fire alarm activating, and each resident had their own personal emergency evacuation plan. The inspector reviewed each of the resident's plans which were all

up-to-date and outlined the supports they may require in evacuating.

Regular fire drills were completed, and the provider had demonstrated that they could safely evacuate residents under day and night time circumstances. Residents spoken with were aware of evacuation routes and staff were knowledgeable of the individual supports required by residents to assist with their timely evacuation.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had not ensured adequate support arrangements were in place in the care and support of residents' who had assessed behavioural support needs. For example, where behavioural related incidents occurred, residents did not have positive behaviour support plans in place, which outlined clear interventions to be implemented by staff, as and when required.

The inspector completed a review of behavioural incidents in the centre. There was a total of 38 behavioural incidents logged by staff members in relation to one resident dating back to January 2023. The inspector was shown evidence that a positive behaviour support referral had been made on 14 April 2023. However, on the day of inspection positive behaviour support reviews, recommendations or plans were not in place for residents' who required them.

This was concerning considering the frequency of behavioural incidents that were occurring in the home which were having a negative impact on residents and their peers.

The inspector found that the provider was not providing positive behaviour supports in line with their own policy.

For example, the provider's policy set out when a resident was on a caseload list as requiring behaviour supports, a relevant health and social care professional would conduct "behavioural assessments in collaboration with stakeholders and then provide clinical oversight on and support in the creation, implementation, monitoring and review of Multi-Element Behaviour Support Plans".

This inspection found this had not occurred despite the high frequency of behavioural incidents occurring in the centre and a referral made to request supports a year previous.

Overall, the provider had not taken appropriate or timely action to alleviate the causes of behaviours and therefore there were no clear plans or time frames in place to address the issues in order to effectively improve the quality of life for residents affected.

Judgment: Not compliant

Regulation 8: Protection

The inspector reviewed incidents that had occurred in the centre through document incident records, daily notes and additional conversations with the person in charge and staff.

On review of three safeguarding preliminary screening reports the inspector observed discrepancies and lack of detail documented in the preliminary records when reviewed against the corresponding documented incidents in the centre.

While the correct safeguarding reporting procedures were being implemented, the information and description of incidents in the preliminary screening reports, was not comprehensive or detailed enough to describe the actual incident that had occurred and the associated level of safeguarding risk presenting or the impact the incidents had on residents.

This meant reported safeguarding concerns were being closed and formal safeguarding plans were not in place to manage the actual level of safeguarding risk presenting.

In addition, The National Safeguarding Office were not being updated if and when there was a change in circumstances, despite specific requests from the office in relation to this.

Furthermore, the provider's organisational safeguarding policy and procedure was not comprehensive and therefore did not reflect adequately National Safeguarding of Vulnerable Adults policy and procedures.

For example, the provider's safeguarding policy did not contain information or clear guidance for staff on the correct safeguarding response to peer-to-peer safeguarding incidents.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Appleview OSV-0001702

Inspection ID: MON-0034206

Date of inspection: 11/04/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC has submitted completed resident and family surveys to the Provider's Quality and Compliance Department whom have incorporated this information into the Annual Review for the designated centre this is completed.

The PIC has reviewed relevant notification required and submitted all notifications to the regulator for Quarter 1 2024 on 29/04/2024,

Notification include

The quarterly returns being submitted are reflective of the restrictive practice log. Where it was identified that a notification was required for a resident due to skin irritation, this was submitted in quarter one. It was also identified on the day of the inspection that a restriction could be reduced, this has also been completed.

The PIC will continue to submit quarterly notifications as required to the regulator.

The positive behaviour support plan required for one resident is in place, and the PIC has ensured that all staff are familiar with same. The PIC will monitor the implementation of the plan, and provide additional guidance to staff.

The Provider's Policy regarding Positive behaviour support has been updated and review and is awaiting final amendments. This policy will also make reference to Positive Behaviour training which will commence organizationally within a 6 month period commencing organizationally in Q4 2024.

The PIC consulted with the National Safeguarding team and sent 3 updated formal safeguarding plans (FSP) to the National Safeguarding office on 3/05/2024 with further

detail required due discrepancies in the Provider's Internal Client Database, and the content of the PSFs submitted to the national safeguarding office. The plan was agreed with the National Safeguarding office provided the plan remains live. A risk assessment relating to the FSPs has also been updated by the PIC to reflect the measures outlined in the FSP. The National Safeguarding office will be updated if here is a change in circumstances relating to safeguarding plans.

On the 25th April 2024, the service provider initiated a provider level review of the systems relating to safeguarding to identify areas risk within the system and to create an action plan to address same.

The service provider will provide a report of the findings and related actions to CH06 within the next 30 days. A review meeting was held on the 01st May 2024.

The Providers Safeguarding Policy has been updated.

The provider has advertised for a new role for an organisational Safeguarding Liaison Officer to enhance governance and oversight of safeguarding.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC has reviewed relevant notification required and submitted all notifications to the regulator for Quarter 1 2024 on 29/04/2024,

Notification include

The quarterly returns being submitted are reflective of the restrictive practice log. Where it was identified that a notification was required for a resident due to skin irritation, this was submitted in quarter one. It was also identified on the day of the inspection that a restriction could be reduced, this has also been completed.

The PIC will continue to submit quarterly notifications as required to the regulator.

Quarter 1, 2 and 3 2023 notification will be retrospectively submitted on the regulator's portal by 21/05/2024

The PIC will continue to submit quarterly and as required notifications to the regulator.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The positive behaviour support plan required for one resident is in place, and the PIC has ensured that all staff are familiar with same, the PIC will also monitor the implementation of same, and provide additional guidance to any staff whom require same.
The Provider's Policy regarding Positive behaviour support has been updated and review and is awaiting final amendments, this policy will also make reference to Positive Behaviour training which will commence organizationally within a 6 month period

commencing organizationally in Q4 2024.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The PIC consulted with the National Safeguarding team and sent 3 updated formal safeguarding plans (FSP) to the National Safeguarding office on 3/05/2024 with further detail required due discrepancies in the Provider's Internal Client Database, and the content of the PSFs submitted to the national safeguarding office. The plan was agreed with the National Safeguarding office provided the plan remains live. A risk assessment relating to the FSPs has also been updated by the PIC to reflect the measures outlined in the FSP. The National Safeguarding office will be updated if here is a change in circumstances relating to safeguarding plans. On the 25th April 2024, the service provider initiated a provider level review of the systems relating to safeguarding to identify areas risk within the system and to create an action plan to address same. The service provider will provide a report of the findings and related actions to CH06 within the next 30 days. A review meeting was held on the 01st May 2024. The Providers Safeguarding Policy has been updated. The provider has advertised for a new role for an organisational Safeguarding Liaison Officer to enhance governance and oversight of safeguarding.	

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 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	31/12/2024
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/12/2024
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	Not Compliant	Orange	30/04/2024

	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.			
Regulation 31(3)(d)	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 injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	21/05/2024
Regulation 31(4)	Where no incidents which require to be notified under (1), (2) or (3) have taken place, the registered provider shall notify the chief inspector of this fact on a six monthly basis.	Not Compliant	Orange	21/04/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to	Not Compliant	Orange	31/12/2024

	behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	31/12/2024
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	31/12/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	15/06/2024
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take	Not Compliant	Orange	15/06/2024

	appropriate action where a resident is harmed or suffers abuse.			