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:	Hall Lodge
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	08 February 2024
Centre ID:	OSV-0001709
Fieldwork ID:	MON-0042592

About the designated centre

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

Hall Lodge is a designated centre operated by Sunbeam House Services CLG. The centre is located in a campus based setting near a large town in county Wicklow. Hall Lodge provides residential care and respite for up to four adults with intellectual disabilities with associated medical and physical support needs. The centre comprises one large property which provides residents with single occupancy bedrooms, a kitchen, communal space living room areas, staff office, staff sleep over arrangements, bathroom and toilet facilities; and a self-contained apartment attached to the property. The centre is managed by a person in charge who reports to a senior services manager, and is staffed by social care workers, nurses, and care assistants. Residents also have access to the provider's multidisciplinary team services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 8 February 2024	10:10hrs to 14:10hrs	Michael Muldowney	Lead
Thursday 8 February 2024	10:10hrs to 14:10hrs	Ann-Marie O'Neill	Support

What residents told us and what inspectors observed

In November 2023, the provider was issued a notice of proposal to cancel the registration of the centre. The notice had been issued based on the grounds of concerns about the fitness of the provider and continued and repeated non-compliance with regulations and standards in the centre which posed a risk to residents' safety and well-being. The provider submitted a written representation to the notice in December 2023 setting out the actions they would take to bring the centre back into compliance and to address governance concerns which were impacting on the fitness of the provider.

An unannounced inspection in January 2024, found that some actions, as set out in the provider's representation, had been progressed. However, overall the provider did not demonstrate that sufficient progress was being made to address the matters of concern.

The purpose of this unannounced inspection was to assess the provider's implementation their representation actions to determine if sufficient and evidential progress had been made. Inspectors used observations, conversations with staff, and a review of documentation, to inform their judgments and recommendation in relation to the aforementioned notice.

The centre was registered to accommodate a maximum of four residents. There were two full-time residents living in the centre; the centre could also provide respite services for another two residents. However, respite services had been suspended since the beginning of the COVID-19 pandemic. The provider was not planning on resuming respite services until they were assured that the current residents' assessed needs were being met. As part of the representation submitted, there were plans for one resident to move to an alternative service provider that could better meet their needs. The provider was engaging with external parties in relation to the move, however, at the time of inspection there was no confirmed date for the move.

The premises comprised a large main building accommodating one resident and an adjoining self-contained apartment accommodating the other resident. Inspectors carried out an observational walk-around of the centre with staff working in the centre.

The main building, intended as a respite service, accommodated one resident. It comprised four resident bedrooms, staff bedroom, staff offices, medication room, catering-style kitchen, boiler room, storage rooms, two sitting rooms, utility area, small bathroom, two large bathrooms (one of which was not in use), and large open plan main living area.

While the large spaces in the building were effective in allowing for increased autonomy in physical movement throughout the centre for the resident living there,

it was not conducive to creating a homely and personalised living environment due to its size, layout and design. However, efforts had been made to make the premises more homely, for example, pictures were displayed on the walls, and the soft furnishings in the main living area were comfortable. On the day of the inspection, further renovation was being carried out, for example, a sitting room was being reconfigured with new furniture to make it a more inviting space to use. The provider had a plan to carry out further renovation works such as replacement of the kitchen.

The resident living there did not communicate their views on the service provided in the centre, but did engage with inspectors through gestures, eye contact, and some words. They briefly spoke about visiting their family. Inspectors observed staff engaging with the resident in a warm and kind manner and also observed an external allied professional, with expertise in positive behavioural supports, were present on the day of inspection. The behaviour support specialist was spending time in the company of the resident and getting to know them and observe their daily routine, this process formed part of a new behaviour support assessment of need for the resident.

Inspectors observed a notice board in the living area that was used to help the resident communicate their choices and plan their daily social activities. The board displayed pictures to support the resident communicate their wishes. The person in charge had also recently sourced new sensory equipment for the resident to use.

The adjoining apartment that accommodated the other resident, comprised of a bedroom with en-suite bathroom, staff office with en-suite bathroom, kitchen/dining room and sitting room. Inspectors did not have the opportunity to meet the resident as they were out with staff during the inspection. As identified during the January inspection, the apartment was found to still require maintenance upgrades. For example, the kitchen required cleaning and upkeep. However, inspectors observed that the oversight and management of environmental restrictive practices in the apartment had improved to promote a more open and accessible environment for the resident.

Inspectors observed improvements to the fire safety, risk management, and infection prevention and control (IPC) measures implemented in the centre. For example, there were better hand-washing facilities, damaged fire doors had been repaired, and there was guidance for staff to follow on managing incidents. These matters are discussed in more detail in the quality and safety section of the report.

Since the previous inspection of the centre, inspectors also observed and noted a more relaxed and pleasant atmosphere in the centre which was partly attributable to some of the recent initiatives introduced by the person in charge.

Inspectors spoke with members of staff during the inspection including the Chief Executive Officer (CEO), person in charge, quality manager, and a social care worker. The person in charge and quality manager spoke about how the provider's representation actions were being implemented to improve the quality and safety of service provided to residents in the centre, and the resources involved. For example,

internal and external multidisciplinary allied professional services. They also acknowledged that further efforts were required, particularly to ensure that residents' needs were fully assessed and being met.

A social care worker told inspectors about recent improvements in the centre such as a reduction in behavioural incidents and increased social activities for residents. They said that the staffing arrangements were adequate, and they were familiar with the IPC measures and emergency plans referred to in the quality and safety section of the report.

Inspectors found that improvements to the quality and safety of the service provided to residents were underway. However, the availability and cohesion of records to clearly demonstrate the provider's efforts to assess and ensure that residents' needs were being met required improvement. For example, meeting minutes from some recent key stakeholder meetings had not been maintained. Furthermore, there was a lack of clarity about who was responsible for monitoring the actions arising from the meetings. The person in charge, quality manager, and CEO acknowledged these deficits.

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

Capacity and capability

Previous inspections of the centre, carried out in 2022, 2023 and 2024, had found high levels of non-compliance with regulations demonstrating repeated failures of the provider to adequately address non-compliance found on those inspections.

A notice of proposal to cancel the registration of the centre was issued in November 2023 by the Chief Inspector in response to the prolonged and ongoing non-compliance found in this centre. The provider submitted written representation in response to the notice which outlined the actions they would take to come into compliance with the regulations and standards to demonstrate fitness on their part. In January 2024, a follow-up inspection to the representation was carried out. The inspection found insufficient evidence to demonstrate that the provider had effectively implemented the representation actions.

This inspection focused on reviewing the provider's progress in implementing and sustaining the actions. Inspectors found that while some actions remained outstanding, there was clear evidence that a significant amount of the actions had been achieved to a reasonable standard which was having a positive impact on the quality and safety of service provided in the centre.

There were positive initiatives being taken by the provider at board director level to enhance their knowledge and understanding of their roles and responsibilities with

due regard to the Health Act 2007 (as amended), and the provider's oversight and scrutiny arrangements had improved which were in turn improving the overall fitness of the provider. These initiatives consisted of a suite of training for board members in governance and regulatory matters, the development of an oversight tracker arrangement which would provide greater assurances and risk identification frameworks for the provider going forward.

Inspectors found that the provider had fulfilled most of the actions outlined in their representation, and that there was improved oversight and resourcing of the centre. The provider acknowledged that they did not have the means to ensure that residents' full needs were being met in the centre, and were engaging with external services to meet these deficits. The provider intended to discharge one resident to an alternative service provider specialised to meet their complex needs, however there was no confirmed date for the move.

Furthermore, the assessment of residents' needs process required a more a comprehensive leadership, oversight and coordinated approach to ensure documented and clearly defined outcomes, directives and recommendations were the outcome of the process. This would ensure the provider could make informed decisions as to whether they could meet residents' needs within their organisation or what type of alternative service provision may be required as part of a discharge process.

Regulation 23: Governance and management

The provider was taking steps to improve the entity's understanding and knowledge of their roles and responsibilities with regards to the Health Act 2007 (as amended) and the the regulations. The provider had also improved their resourcing and monitoring of the centre which was in turn improving the quality and safety of service provided to residents living in the centre. Some improvements were still required and underway at the time of the inspection.

The provider had undertaken a suite of training initiatives for the board of directors of the company to ensure they had a better understanding and knowledge of their roles and responsibilities under the Health Act 2007 (as amended) as a registered provider and a greater understanding of relevant governance codes that they were obliged to understand and implement.

Information provided as part of the inspection demonstrated the provider entity had implemented a large number of actions in this regard which was a positive and responsive initiative to improve the overarching governance arrangements for the organisation.

At operational level within the centre, a number of actions, the provider had committed to undertake as part of their representation, had been achieved to the improve the quality and safety of the service provided to residents, such as

improved fire safety and risk management systems.

However, the provider recognised that they did not have the capacity to meet residents' full needs in the centre and this deficit was impacting on their safety and quality of life. The provider had engaged with residents' representatives and external services to assess and plan for residents' needs, with priority for one resident to move to an alternative service provider.

However, as detailed under regulation 5, the co-ordination of these initiatives required improvement to ensure that any actions were recorded, monitored, and carried through.

Judgment: Substantially compliant

Quality and safety

The provider had implemented actions, as outlined in their representation, to improve the quality and safety of the service provided to residents in the centre resulting in improvements under most regulations inspected. However, further improvements were still required, particularly in relation to assessment of residents' needs and the associated arrangements required to coordinate the process.

As part of the provider's representation, the provider had initiated a comprehensive multidisciplinary allied professional led assessment of need for each resident living in the centre. While there had been scheduled multidisciplinary meetings and reviews, inspectors found that the information from these reviews was not collated in an organised manner and was difficult to retrieve. For example, some important meetings had recently taken place however, there was limited recorded information on the outcomes from these meetings.

Overall, the co-ordination of the assessments of residents' needs required considerable improvement to ensure that the outcomes were being monitored and effectively responded to.

The centre was located on a campus operated by the provider. It accommodated one resident in a self-contained apartment, and one resident in the main building that was intended for providing respite services. Parts of the centre had been nicely decorated, and the provider had more long-term plans for the renovation of the centre. However, its current layout, design, and size was not appropriate to meet the needs of long-term residential residents' in terms of providing a home like environment.

Inspectors found that the provider had strengthened the fire safety systems in the centre by implementing most of the associated actions in their representation, such as updating fire evacuation plans and repairing damaged equipment. They had also enhanced the infection prevention and control (IPC) measures to protect residents

from the risk of infection, for example, IPC audits had been carried out and appropriate cleaning chemicals and equipment were readily available in the centre.

Improvements were also found in relation to the review and mitigation of risks presenting in the centre. The risk register had been updated, and where required, high rated risks were escalated to the provider's risk register. Inspectors also found that measures to control risks in the centre were in place as detailed in associated risk assessments.

The person in charge had also ensured that relevant information and plans were readily available for staff to follow in the event of an emergency.

The provider and person in charge had implemented actions to enhance the behavioural supports provided to residents. The provider had engaged external services to assess residents' behaviour support needs and develop associated care plans for staff to follow. The person in charge was also arranging training for staff in this area.

The oversight and management of restrictive practices in the centre had also improved. Some environmental restrictions have been removed as they were deemed to be no longer required, and those in place had been subject to a risk assessment and were approved for use by the provider's human rights committee.

The provider's speech and language therapy department had carried out assessments of residents' communication means to inform support plans for staff to follow to support residents in exercising choices. Communication aids were also in place, and the person in charge had scheduled bespoke communication training for staff to attend.

Although, efforts had been made to promote residents' rights in the centre, the premises remained institutional in aesthetic in design and layout, and did not present a 'home like' environment for residents to live in on a full-time basis.

Regulation 17: Premises

Inspectors found that the provider had implemented actions to address some of the deficits in the premises for it to be more homely and better maintained. However, the premises remained unsuitable for residents' full-time residential needs, and the design continued to present an institutional aesthetic (despite efforts to make it more homely such as reducing the use restrictive practices, display of photographs, and replacing old furniture).

During the inspection, inspectors observed maintenance workers installing new furniture, and repairing damage to the exterior of the premises. Other renovations recently carried out, included:

- Gaps where external doors met the floor had been filled.

- The screen over the television in the apartment had been cleaned, and the screen over the television in the main building had been removed.
- Unused pipes in the unused bathroom had been secured.
- A padded headboard had been fitted to reduce noise travel between residents' bedrooms.

Inspectors observed areas of the premises requiring attention, for example:

- In the apartment, the kitchen curtains were dirty. The floor and a radiator cover was damaged in places.
- The large kitchen required renovation, and an unused insect control device required removal.
- The floor in the main living area was marked with small dents.

The provider had plans for more renovation works once one of the current residents moved to another service (which there was no confirmed date for) and the future operation of the centre had been determined.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had improved the risk management procedures in the centre to ensure that risks presented in the centre were reviewed, and better systems were in place to respond to emergencies. For example:

- Risk assessments had been reviewed and updated by the person in charge and senior services manager, and outlined the required control measures to be implemented.
- Appropriate control measures were in place to respond to specific risks, for example, night-time staffing levels increased.
- High risks rated 'red' had been escalated to the provider's corporate risk register for attention.
- A written emergency plan for responding to serious behaviours of concerns had been prepared, and was readily available to staff.
- 'On-call' emergency information was available to staff in the event of further guidance being required during an emergency.
- The person in charge had ensured that new staff working in the centre received a thorough induction which included the emergency plan and on-call arrangements.
- Incidents were discussed at team meetings for review and learning purposes.

The improvements demonstrated that the provider was ensuring that risks in the centre were better assessed, communicated, and managed to reduce the risk of harm to residents.

Judgment: Compliant

Regulation 27: Protection against infection

Inspectors found that actions to improve the infection prevention and control (IPC) measures in the centre had been implemented as outlined in the provider's representation. For example:

- Additional hand-washing dispensers were in place, and there were systems to ensure that the dispensers were refilled when necessary.
- Material cloths previously used by staff to dry hands had been replaced with paper cloths to reduce the risk of infection cross contamination.
- Equipment and chemicals for the cleaning of bodily fluid spills and management of soiled laundry was available to staff with accompanying guidance for them to follow.
- Hand hygiene posters were displayed to prompt good practices.
- There was a daily cleaning checklist, and it was regularly reviewed by the person in charge to ensure it was completed.
- Detailed IPC audits (including audits by the provider's quality team) had been carried out to assess the implementation of IPC measures in the centre.
- Additional IPC training was being arranged for staff to complete.

The improvements to the IPC measures implemented in the centre demonstrated that IPC hazards and risks were being appropriately managed to protect residents against infection.

Judgment: Compliant

Regulation 28: Fire precautions

Inspectors found that the provider and person in charge had implemented most of the fire safety related actions as outlined in their representation to address previously found deficits and to strengthen the effectiveness of their fire safety systems. For example:

- Fire doors (with the exception of one which had been very recently damaged) were in good working order.
- There were arrangements for the regular checking of fire doors and fire safety equipment to ensure they were in good working order.
- The fire evacuation plan for the centre had been reviewed and updated.
- Residents' individual fire evacuation plans had been updated to better outline the supports they required to evacuate the centre.
- Regular fire drills were scheduled to test the effectiveness of fire evacuation plans.

- Staff had completed fire safety training.
- The key to open one resident's bedroom door in the event of an emergency was readily available (however, checks of the key had not yet been incorporated into the weekly fire checks as committed to in the provider's representation).

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Improved arrangements were required to ensure each resident was assessed using a multidisciplinary allied professional approach resulting in all assessed needs for residents being clearly identified, a corresponding support plan put in place in response to those needs which clearly set out and could provide staff with appropriate and accurate guidance and direction on how to effectively support and care for residents.

Previous inspections of this centre had found a consistent pattern of ineffective personal planning arrangements for residents and a lack of clear and up-to-date information and assessments, which in turn meant it was difficult to ascertain what residents' assessed needs were and if the provider was meeting those needs.

As part of the provider's representation to the notice of proposal to cancel the registration of the centre, the provider had initiated a comprehensive multidisciplinary professional led assessment of need for each resident living in the centre. While it was evidenced that there had been scheduled multidisciplinary meetings and reviews, overall the information from these reviews was not collated in an organised manner and was difficult to retrieve.

Some important meetings and reviews by multidisciplinary professionals and other stakeholders, with important roles in each resident's life, had taken place in recent weeks. However, there was limited information or recorded minutes or documented directives or outcomes from these meetings.

Overall, while it was demonstrated there was an improved arrangement in place to ensure residents' needs were being assessed, the co-ordination of the process required considerable improvement to ensure important information, directives, recommendations and decisions were not being lost as a result of the poor oversight and lack of co-ordinated approach to the process.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Inspectors found that the provider and person in charge had strengthened the arrangements for supporting residents with behaviours of concerns, and for the management of restrictive practices in the centre.

Residents' behaviour support plans had been updated to reflect the associated strategies to be in place. The provider had also sourced external services to assess residents' behaviour support needs, and to then develop associated support plans for staff to guide. This work had commenced, and on the day of the inspection, there was a behavioural specialist in the centre working with residents.

Staff were also completing training to support them in being able to respond appropriately to residents' behaviours of concern.

The management of restrictive practices in the centre had improved, for example, some environmental restrictions had been removed as they were no longer deemed required. The restrictions implemented in the centre were recorded on a log maintained by the person in charge, subject to a risk assessment, and had been approved for use by the provider's human rights committee. The use of restrictive practices was also a standing agenda item at staff team meetings for discussion.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider and person in charge had made efforts to promote residents' rights in the centre, including their right to communicate and make decisions.

The arrangements to support residents to communicate had improved. The person in charge had engaged with the provider's speech and language therapy department to assess a resident's communication needs, and to develop a support plan for staff to follow. The person in charge had also arranged for staff to receive bespoke training on how to effectively communicate with the resident. Inspectors also observed a visual communication board in the main living area. The board displayed pictures and was used to help them plan their daily routine and chosen activities.

Inspectors also found that the use of restrictive practices in the centre had reduced, and was having a positive impact in promoting residents' rights to privacy and access around the centre.

However, the location, layout and design of the centre continued to present an institutional.

For example, one resident continued to live in a large building on their own with unoccupied bedrooms and spaces which meant they were not being provided with a home like environment and were not being given the opportunity to engage and mix with peers. Another resident living in the centre required single living occupancy arrangements therefore, while two residents lived in the centre their individual

needs were not compatible and therefore they did not spend time in each others company.

The location of the centre also presented a challenge for residents in terms of their ability to easily access and integrate with their local community. The centre was located in a congregated setting arrangement and residents required access to transport to access their local amenities and community.

In addition, the provider was still undertaking an assessment of residents' individual needs, and until this assessment was completed, it was unclear if residents' rights to individualised care and support was in place.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Hall Lodge OSV-0001709

Inspection ID: MON-0042592

Date of inspection: 08/02/2024

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 provider has in place a tracker which has recorded all actions relating to assessments and recommendations and monitors these on a regular bases. There is a steering group in place which meets and reviews actions bi weekly. There are internal MDT meetings which meet every three weeks for the next nine weeks. The assessment of need is being updated to include all assessments by allied health care professionals to be consolidated into one plan.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The floor and Radiator cover will be assessed and repaired by 31/04/2024 The kitchen curtains have laundered and have been re hung. A contractor has been appointed to carry out renovate the kitchen and bathroom. The unused insect control device will be removed as part of these works. The flooring in the sitting room will be replaced with anti slip wood effect vinyl as part of the renovation works. The provider has a planned date for the renovation works to commence 25th March , works are planned into 4 stages. Stage 1: Temporary arrangement set up for Kitchenette, medical room ,Sitting room set and Exterior drain works at front gate Stage 2: Kitchen refurb including replacing floor in living room. Stage 3: Parker Bathroom refurb/ staff toilet refurb/ laundry room floor replacement Stage 4: Exterior roof repair	
Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The provider has in place a tracker which has recorded all actions relating to assessments and recommendations and monitors these on a regular bases.
There is a steering group in place which meets and reviews actions bi weekly.
There are internal MDT meetings which meet every three weeks for the next nine weeks.
The assessment of need is being updated to include all assessments by allied health care professionals to be consolidated into one plan which will provide guidance and direction on how to effectively support and care for residents.

All meeting minutes are now saved on the providers database, going forward meeting minutes will be completed promptly and readily available on the providers database.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
There will be a suite of training for staff on positive behavior support designed and delivered, this will commence on 27th March an external Behavior Specialist has been commissioned to do this.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The provider has commenced a process in order to support both residents to find alternative accommodation that meet their assessed needs.

Currently residents are supported to engage in regular activities outside the center. One resident is supported to engage with their friend on a more regular basis. One resident is also being supported to attend music sessions with his peers.

Both residents have access to daily transport supported by staff to attend activities of their choice. The center is located approximately 2 km outside the large town and has an accessible footpath from the gate of the campus directly into the town.

The assessment of need is being updated to include all assessments by allied health care professionals to be consolidated into one plan which will provide guidance and direction on how to effectively support and care for residents.

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/06/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/06/2024
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/06/2024
Regulation 17(7)	The registered provider shall	Substantially Compliant	Yellow	30/06/2024

	make provision for the matters set out in Schedule 6.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30/04/2024
Regulation 05(2)	The registered	Not Compliant	Orange	30/06/2024

	provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/06/2024
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/04/2024
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal	Substantially Compliant	Yellow	30/04/2024

	development in accordance with his or her wishes.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/04/2024
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Substantially Compliant	Yellow	30/04/2024
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	Substantially Compliant	Yellow	30/04/2024

	personal information.			