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:	Adult Respite
Name of provider:	St Christopher's Services Company Limited by Guarantee
Address of centre:	Longford
Type of inspection:	Unannounced
Date of inspection:	09 and 10 August 2022
Centre ID:	OSV-0001841
Fieldwork ID:	MON-0032952

About the designated centre

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

Adult Respite Service comprises two houses in County Longford. The centre can accommodate up to seven residents in total, with six registered beds in one location and one registered bed in the other location. The service provides residential and planned respite care to a number of residents, both male and female, and can accommodate emergency admissions. The first building is a large dormer style bungalow located in a quiet housing estate. On the ground floor, there is a bright entrance hall, four bedrooms, of which two are en-suite, an accessible large kitchen and dining area, a sitting room and a snug/relaxation area. It also has a self-contained apartment located in the side annex of the house that has one bedroom, bathroom and kitchen/living area. The main bathroom of the house has a Jacuzzi bath and shower facilities. There is an accessible sensory garden and outdoor seating area at the back of the residence. The second building is a large three-storey house. The downstairs of the house includes the registered bedroom and the living area for the resident. The upper storeys of the house are not in use by the resident. Residents have access to local amenities such as shops, bars, and cafes. There is a team of nurses, social care workers and support workers that provide support to residents on a twenty-four-hour basis.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Tuesday 9 August 2022	14:00hrs to 19:00hrs	Angela McCormack	Lead
Wednesday 10 August 2022	10:15hrs to 15:00hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection to monitor compliance with the regulations. The provider had submitted an application to vary a condition of registration which involved changing the layout, and the purpose and function of some rooms in one location. This application and changes were also reviewed on this inspection.

The designated centre consisted of two houses in County Longford, which were located approximately 30 kilometres from each other. One house was included as part of this designated centre in 2020 during the COVID-19 pandemic to support a resident to 'cocoon' and now provided full-time care and support to one resident. There were plans in progress for this resident to move to a new home in the coming months. The other location was a respite house and could accommodate up to six residents. It provided respite care to a number of residents on a planned basis. It also provided full-time care to one resident in a self-contained apartment. This was reported to be on a temporary basis until they move to their new home. The application to vary involved reconfiguring the rooms in the respite house to create a self-contained apartment in the side annex of the house. The inspector was informed that the plan for this was to accommodate one resident until they transitioned to a new home, and then it would be used to accommodate any future emergency admissions.

Overall the inspector found that residents received a person-centred service and good quality care and support. However, the governance arrangements did not ensure that there were clear lines of accountability or that there was a clear and robust governance structure. This impacted on the oversight by the person in charge and provider and led to some areas, particularly in one location, requiring improvements in order to comply fully with the regulations. Improvements were required in staff training in behaviour management, reviews of restrictive practices, fire safety, the submission of statutory notifications and auditing practices. These will be discussed in more detail throughout the report.

On arrival to the respite house on the first afternoon of the inspection, the inspector met briefly with two staff and one resident. The inspector sat with one resident in the sitting room and they interacted on their own terms. They were watching a game show on television, and had just eaten lunch and they informed the inspector about what they had chosen for lunch. They spoke briefly in their own way about the photographs that were on display in the sitting-room and about things that they liked. The inspector met with another resident who entered the sitting-room at this time. They spoke briefly about the weather and about their plans for the evening which involved going out shopping with staff. When asked if they liked coming in for respite breaks, one resident said they did and one said they did not.

The inspector met with another resident who was living in the self-contained apartment. They had been out earlier that day attending a healthcare appointment

and also visited a nearby amenity. They were observed relaxing on the couch, listening to music and having a beverage. They agreed for the inspector to look around their living area and they appeared happy and content in their environment and with staff supporting them. They spoke briefly about their likes and interests when prompted, and also mentioned about having had a telephone conversation with family members earlier that day. Staff supporting residents were observed to be treating them with respect and dignity, and residents appeared relaxed in their company and with each other.

The respite house was bright, airy and spacious for the needs and numbers of residents. In addition to the self-contained apartment which had one bedroom, there were four bedrooms on the ground floor, and one additional bedroom upstairs which was used for storage at this time. The upper floor also contained the staff office room, which had been changed from being downstairs to allow for the creation of the self-contained apartment. This change in room functions appeared to be a positive addition to the centre, as it allowed a space for one resident to have their own living area in an annex connected to the main house when in for an emergency respite stay.

The self-contained apartment was bright, clean and comfortably furnished, There were exit routes from the bedroom and the kitchen/living area as well as through the main entrance hall which led to double doors to the front of the house. The doors off the kitchen and bedroom led to a back garden area which had accessible ramps and hand rails, and contained garden furniture and potted shrubs and flowers. There was a locked gate which was an access point from the garden area to the assembly point at the front of the house. This was reported to be locked due to the risk of intruders. This had not been identified as an environmental restriction affecting residents' ability to freely move around their home. On discussion with the service manager on the second day of inspection, they had begun to look at an alternative to this.

The main house itself was clean, bright and spacious. The four bedrooms downstairs included two bedrooms that had en-suite facilities. They were bright and spacious, with good storage facilities for respite residents to store their personal belongings. In addition, some bedrooms had televisions and music players. There was a large bathroom which contained a Jacuzzi bath and level access shower. There were ample communal areas for residents to relax and one small room was in progress of being decorated to provide another living area for residents to relax in and watch television.

On the morning of the second day of inspection the inspector visited the other location that formed the designated centre. This was a large detached three storey house that could accommodate one resident on the ground floor. The upper storeys of the house were not in use, and the inspector was informed that there were no future plans to develop this or to request a change to the bed numbers. The ground floor included a spacious living area, including a kitchen/dining area, sitting room, bedroom and a room that was designed as a sensory room for the resident. This room contained various sensory items, photographs and art work created by the resident. The staff on duty spoke about the resident's needs, likes and interests and

described about how choices were offered. They appeared knowledgeable about the resident's specific care and support needs. The staff member reported that they had worked with the resident for over two years, and the inspector was informed about some staff having worked with the resident for a number of years. Familiar staff to ensure continuity of care was very important in supporting the resident with their specific care needs and communications. The resident was supported on a one-to one basis day and night in this location, with waking night cover provided. The inspector briefly met the night duty staff that morning before they were leaving after finishing their rostered shift. The resident was reported to be in bed asleep as they had had a poor night's sleep. Therefore the inspector only got to meet them very briefly later that afternoon.

Residents were observed to be supported with their needs in a person-centred manner. Most residents were reported to usually attend day services external to the centre. At the time of inspection, the day services were closed for a few weeks holidays therefore residents were supported by the centre's staff team in engaging in activities of choice from the centre at this time. Residents were observed coming and going to various outings throughout the day.

Residents' meetings were held regularly in the respite location. These meetings were planned for when a new group of residents came in for respite. This meeting allowed a forum for residents to decide what meal options and activities that they would like while on their respite stay. This meeting note was then posted in the kitchen so that all staff were aware of what residents' plans and choices were for their respite break. One resident had chosen to go shopping for items and this was occurring on the day of inspection. In addition, there were a range of easy-to-read documents accessible in the hallway of the respite location including information on; the residents' guide for the service, the annual review of the service, complaints and compliments and safeguarding information.

A review of documentation including audits, residents' care and support plans and meeting notes indicated that residents were provided with person-centred care and support where their choices and wishes were respected. There was evidence that residents who required support with making choices in their lives were supported to communicate their wishes in their preferred communication methods and that family representatives were consulted with about care and support where appropriate and relevant.

Through staff and resident discussions and through a review of documentation and photographs, it was found that residents enjoyed a variety of activities in the house and in the community. These included; art work, gardening, painting, jigsaws, listening to music, have foot spas and hand massages, going for day trips to the beach and other attractions, shopping trips, having meals out, going to the cinema and accessing other local amenities and walks.

In general, residents were found to be provided with individualised, person-centred care that met their specific needs. However, the governance and management arrangements of the designated centre required improvements to ensure that regulatory compliance was achieved, and to ensure effective monitoring and

oversight of all parts of the centre.

The following sections of the report will discuss the capacity and capability and about how this impacts on the quality and safety of care and support.

Capacity and capability

The inspector found that the governance and management arrangements in Adult respite designated centre required improvements to ensure that there were clear lines of authority and responsibility, and that robust governance structures were in place to ensure effective oversight by the person in charge and provider. The failure to ensure this led to ineffective auditing practices and some areas of non compliances with the regulations, particularly in one location of the centre.

The person in charge worked full-time and had responsibility for this designated centre only. It was found on inspection that the person participating in management (PPIM) no longer worked in the organisation, and had in fact left the previous year; however the provider had not notified the Chief Inspector within 28 days of this change, as required in the regulations. The inspector requested that this was addressed as a matter of urgency, and the relevant notification was submitted to the Chief Inspector that day.

In addition, it was found that in one location of the centre there was a local manager in place who had responsibility for managing and overseeing practices in this house; however they had no reporting relationship to the person in charge, but reported directly to the organisation's residential and respite manager. This was not in line with the organisational structure detailed on the Statement of Purpose and function of the designated centre. Furthermore, this arrangement did not allow for robust and effective monitoring of this location by the person in charge. A number of documents and audits in this location had been signed off by the local manager and by the previous PPIM, as being either the 'person in charge', 'unit head' and 'centre manager', which did not demonstrate clear lines of responsibility and accountability nor an understanding of the role and remit of the person in charge under the Health Act 2007 and associated regulations.

In addition, it was found that the last two provider unannounced audits did not include auditing of this location. Therefore, the management arrangements and the oversight and monitoring by the provider and person in charge required significant improvements to ensure that this location was monitored appropriately and effectively at all times.

Notwithstanding this, the care and support provided to the resident by the staff team in this location was to a good quality. There were some monitoring arrangements in place by the local manager and residential and respite manager, and the service was individualised to meet the resident's specific support needs. However, there were areas for improvements found on inspection relating to staff

training, in ensuring that there were clear guidelines in place for a restrictive practice that may be required and in some documentation such as the reviews of risk assessments and the annual review of the assessment of needs.

There were a range of audit tools and an audit schedule developed for auditing the designated centre. Audits were completed in Infection control, health and safety, medication management, personal plans, finances and staff files. There were also daily and weekly checklists completed on fire safety arrangements. In general, the inspector found that where actions for improvements were identified, that these were completed in a timely manner.

However, in one location some audits and reviews were not consistently completed in line with the provider's requirements. For example; the monthly fire and safety audit was not completed last month, which meant that it was not identified that the fire fighting equipment was due for annual inspection. The service manager addressed this on the day when it was brought to their attention, by arranging a date for the annual inspection to occur. In addition, some resident's documents in one location, including risk assessments and the annual assessment of need, had not been reviewed as required.

The provider had ensured that an annual review of the quality and safety of care and supported was completed. This had been completed separately for the two locations that formed the designated centre, and demonstrated good consultation with residents and their family representatives. The provider had completed unannounced six monthly visits as required in the regulations. However, the last two unannounced audits did not include a review of one location. This meant that there was ineffective monitoring and oversight by the provider for this location. Therefore, some areas that were found to require improvements on this inspection, such as reviews and notifications of restrictive practices, had not been identified through the provider audits.

There appeared to be an appropriate number and skill mix of staff to support the needs of residents. Each location had a waking night staff, with the respite location having up to three waking night staff each night. There were two part-time staff vacancies at the time for the resident who lived in the self-contained apartment, and this was covered by regular locum staff until the appointments were made. There was a staff rota in place which was well maintained and accurate as to what staff were working.

Improvements were required in the areas of staff training, as not all of the staff sample reviewed had completed the mandatory behaviour management training. This related to one location of the centre. In addition, it was not clear from the fire training records that staff in this location had received the specific training for the location in which they worked. The inspector was informed that this may have been an administrative error; however this had not been identified through any of the audits completed in the centre. These training gaps are covered under the regulations for positive behaviour support and fire precautions.

There was a system in place for the recording and review of incidents that occurred

in the centre. A sample reviewed in the respite location demonstrated that a comprehensive review and analysis of incidents had occurred, with evidence of learning from incidents noted and incidents discussed at team meetings. There was also an auditing system in place for incidents and a recording system about events that were required to be notified to the Chief Inspector through monitoring notifications. However, it was found that one injury sustained by a resident in the last quarter had not been included on the quarterly notification, and one environmental restriction involving a locked gate which restricted residents' free access around their home, had not been included on the quarterly notifications. It was explained to the inspector that this had not been identified as a restrictive practice due to the rationale for it's use being to prevent intruders accessing the garden, rather than for preventing residents from leaving the garden area. At the end of the inspection, the service manager spoke about a possible alternative to this which would allow residents to freely access all parts of their home environment should they wish to. In addition, the service manager explained that they had omitted to include the restrictive practices in one location for the previous year, and these notifications were all retrospectively submitted on the day.

The statement of purpose submitted as part of the application to vary a condition of registration was reviewed and required some amendments to ensure accuracy regarding floor dimensions and functions of some rooms and about the organisational structure.

In general, while the service had systems and procedures for auditing the centre, it was found that improvements were needed, particularly for one location more so than the other. Of significance, the management arrangements and structures in place were not in line with the statement of purpose, nor did it support the person in charge in having effective oversight of the entire designated centre. This required improvements, as did the provider's oversight and auditing of one location of the centre.

Registration Regulation 7: Changes to information supplied for registration purposes

The provider did not notify the Chief Inspector of the change in the person participating in management of the centre within 28 days of the change, as required in the regulations.

Judgment: Not compliant

Regulation 15: Staffing

There appeared to be an appropriate number and skill mix of staff working in the designated centre to meet the needs of residents. A staff rota was in place which

was well maintained and accurate. Staff files were not reviewed on this inspection.

Judgment: Compliant

Regulation 23: Governance and management

Improvements were required in the governance and management arrangements, including the arrangements for oversight and monitoring of all parts of the designated centre by the person in charge and the provider.

- The governance structure was not clearly defined, and was not clear on the roles and responsibilities for the person in charge in one location of the designated centre.
- There was a local manager in place in one location who did not have a direct reporting relationship to the person in charge, but reported directly to a senior manager. This arrangement impacted on the person in charge's oversight of this location.
- The management systems in one location did not ensure that effective monitoring and oversight was occurring by the person in charge.
- Some audits and reviews were not completed in line with the provider's requirements in one location of the centre.
- Unannounced provider audits did not include all parts of the designated centre leading to poor oversight of this location by the provider.
- The management arrangements in place impacted on the ongoing reviews of some documentation, the failure to submit some monitoring notifications to the Chief Inspector and resulted in the failure to identify actions required for improvements and regulatory compliance.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose submitted as part of the application to vary Condition 1 of this registration required some amendments to ensure that it fully met all of Schedule 1 requirements.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge did not ensure that all relevant information to be submitted on the monitoring notifications were completed.

- One incident of resident injury was not submitted on the last quarterly notifications.
- One incident of an environmental restriction in one location was not included on the quarterly notifications.
- Restrictive practices in one location of the designated centre had not been included on the quarterly notifications for the last four quarters.

All monitoring notifications were retrospectively submitted on the day of inspection.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that residents were provided with person-centred, individualised care and that practices in place supported residents to live a life of their choosing and supported them with life choices. However, improvements were required in fire evacuation plans, risk management documentation, the ongoing review of some residents' documents, and in ensuring that there were clear guidelines and a clear rationale in place for a restrictive practice for one resident.

A sample of residents' care and support plans were reviewed in both locations of the designated centre. In general, it was found that comprehensive assessments were completed for residents' health, personal and social care needs. Care and support plans were developed where the need was identified, and these were found to be kept under review and updated with any changes. However, one resident's assessment of needs document had not been reviewed annually, although care plans had been updated. This lack of oversight is covered under the governance arrangements and monitoring of the centre.

Residents and family representatives (where relevant) were consulted about residents' care and support needs and residents were supported to identify and achieve personal goals while staying in the centre. The person in charge spoke about the system for person-centred planning of goals for respite users, which involved working closely with the day services that residents attended, for long term goals, and that the centre supported residents to identify short term goals and activities of choice for their respite stay. A review of personal goals for full-time residents demonstrated that goals identified had been achieved, with new personal goals identified and under review. For example, one resident had identified personal goals of completing a walking challenge and walking barefoot on a beach, both of which had been achieved.

There were transition plans in place for some residents to transition to a more suitable long-term residential placements. The service manager spoke about these

plans and about how residents' needs were assessed and reviewed with members of the multidisciplinary team (MDT) to include reviews of environmental factors, staffing and compatibilities. There was evidence of transition plans in place, meetings held with family representatives and discussion with residents. The inspector was informed about the factors influencing the timing of certain aspects of the transition plan, such as timing when to inform residents about the move date etc. so to reduce any anxiety on residents.

Residents were supported to access allied healthcare professionals as required and recommended. Healthcare appointments were facilitated in line with residents' needs and wishes. Social stories were in place for healthcare related issues such as COVID-19 and the use of vaccinations, to aid residents' understanding of these topics. There were a range of care and support plans in place for identified healthcare needs and there was evidence that ongoing monitoring was occurring for identified healthcare issues. Residents had access to multidisciplinary supports such as physiotherapy, behaviour therapy and psychology services, as needed. Each resident had a Hospital Passport (a document to be used in the event of a hospital admission) in place, which included all relevant details for continuity of care and support in the event of a hospital stay.

Safeguarding of residents was supported through reviews of incidents that occurred, staff training in safeguarding vulnerable adults and the provision of a safeguarding policy and procedure and intimate care policy. The safeguarding policy was overdue for review and the inspector was informed that this was planned to be reviewed in line with national changes to policy. Residents who required support with intimate and personal care had plans in place which outlined areas of independence and areas where support was required. There was an easy-to-read document to support residents' understanding of safeguarding and how to identify abuse. Safeguarding concerns were taken seriously and the safeguarding procedure was followed where any concerns that could indicate abuse were found. Where residents required safeguarding plans these were in place. They were found to be kept under review with measures taken to minimise the risk of any future safeguarding concerns, which included ongoing reviews about compatibility of residents receiving respite care together.

Residents who required supports with behaviours of concern had behaviour plans in place, which included input from the relevant MDT members as required. For residents who may present with anxiety behaviours there were protocols and easy-to-read social stories in place to provide support with anxiety behaviours. The protocols for restrictive practices involving the use of PRN medicines (a medicine only taken as required) to support residents with behaviours of concern were comprehensive and clear in guiding staff as to it's use.

However in one location, one resident's behaviour support plan was overdue for review, and it was not clear from the description of behaviours what the risk was that may indicate the necessity to use a physical restrictive practice on transport. While this restrictive practice was under review with the restrictive practices committee and it was noted that its use had been reduced to only being used in an 'emergency' scenario; the care plan in place did not indicate what constituted an

'emergency' nor what the risk was to warrant it's use. The lack of clear guidelines and description of the behavioural risk, could pose a risk that this practice would be used inappropriately. This required review and ongoing monitoring by the person in charge to ensure that it was used as a last resort and for the shortest duration.

There were policies and procedures in place for risk management and fire safety management. The risk management policy was reported to be in draft form at present, as a review date due of November 2021 was noted on the policy in place. In general, there was a good risk management system, with assessments completed for any identified risk relating to residents and regarding the centre. These were generally comprehensive and kept under review. However in one location of the centre, some of the resident's risk assessments which were due for review 'biannually', had not been reviewed since the assessments were completed in July 2021. In addition, one risk assessment regarding safeguarding and lone working did not include all of the control measures that were in place, such as the development of a safeguarding plan and a monitoring system for injuries. In addition, the risk description was not clear as to what exactly the specific risk was. This required review.

In relation to fire safety, there were arrangements in place in both locations for fire safety including; staff training, fire safety checklists, fire audits, fire drills and fire evacuation plans. It was found that for one resident who lived in the self-contained apartment of the respite house, that their personal emergency evacuation plan (PEEP) required review to ensure that it was clear about the arrangements to evacuate them to the assembly point in the event of a fire occurring during and post a healthcare event that had been identified as possibly occurring. In addition, a fire drill had not been completed under the scenario of the resident requiring to exit from the bedroom exit and accessing the assembly point through the locked gate.

In addition, in the other location while the resident's PEEP detailed the supports required, the centre fire evacuation plan required updating to reflect the specific arrangements to evacuate the resident from the centre, so to reduce any potential for confusion. Staff were reported to receive an aspect of fire training that was specific to the location in which they worked. Some of the staff training records stated that fire training was completed for another location, and not the location that the staff members worked in. The inspector was informed that this was possibly due to an administrative error, but this had not been identified in any audits. Furthermore, the monthly fire audit had not been completed the previous month, therefore it had not been identified that the fire equipment was due for the annual inspection. It was also noted that the fire alarm panel in this location was covered over by a wooden cupboard that appeared to be locked, but which was subsequently opened after a period of time by staff who said it had not been locked after all. Following a discussion with the person in charge, it was felt that there was no requirement for this fire alarm panel to be concealed by this wooden cupboard and they agreed to review this.

In summary, it was found that residents were supported with their needs and that they were provided with a person-centred service that aimed to promote choices and rights. However, due to the management arrangements in place as outlined in

the previous section of the report, while there were no high risks to residents, some aspects of the care and support of residents were impacted by the governance and oversight arrangements that was in place.

Regulation 25: Temporary absence, transition and discharge of residents

There was evidence that residents who were due to transition from the centre had transition plans in place and supports were in place to aid a smooth transition between services.

Judgment: Compliant

Regulation 26: Risk management procedures

Some aspects of risk management required improvements in one location of the centre.These related to reviews of some risk assessments within the time-frames set out, in ensuring that risk descriptions were clear about what, and to whom, the risk related and in ensuring that all of the control measures in place for an identified risk was included on the assessment form.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Improvements were required in fire safety management;

- In one location, a resident's PEEP required updating to ensure that they could be safely evacuated to the assembly point.
- A fire drill had not been completed under the scenario of a resident evacuating from a bedroom exit through a locked gate to access the assembly point to ensure that this could be done in a timely manner.
- In one location, the monthly fire audit had not been completed the previous month.
- The fire extinguishers were due for the annual inspection in one location. A date for this to occur was set prior to the inspection ending.
- The fire evacuation plan in one location required review to ensure that the specific instructions for evacuating the resident was clear.
- The concealment of the fire alarm panel in one location required review.
- Staff training records required review to ensure that staff were provided with suitable training in line with the provider's training requirements.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents were found to have comprehensive assessments of needs completed to assess health, personal and social care needs. Care and support plans were kept under review and provided clear information on the supports required. Reviews occurred with residents and their family representatives as appropriate. Residents were supported to identify and achieve meaningful personal goals for the future.

Judgment: Compliant

Regulation 6: Health care

Residents were supported to access healthcare appointments and allied healthcare professionals, as required. Easy-to-read documents and social stories were available to support residents' understanding of health related topics.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviours of concern and anxiety behaviours had care plans in place.

However, in one location of the designated centre, one resident's behaviour support plan was overdue for review and it did not include a clear description of behaviours that may pose a risk and require the use of a restrictive practice, that was referenced in other documents. In addition, the use of this restrictive practice was recorded as being used in 'emergency' situations, however there were no guidelines or information in place about what may constitute the 'emergency' and what the risk posed might be.

A sample of staff training records reviewed indicated that two staff in one location did not have the required behaviour management training.

Judgment: Not compliant

Regulation 8: Protection

Residents were supported to be safeguarded in the designated centre through staff training, reviews of incidents and adherence to policies and procedures in place.

Judgment: Compliant

Regulation 9: Residents' rights

There was evidence that residents' rights were upheld, and that they were respected and supported to live a life of their choosing.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 15: Staffing	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Adult Respite OSV-0001841

Inspection ID: MON-0032952

Date of inspection: 09/08/2022 and 10/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: Notification of changes to PPIM for one location submitted via NF31 on 09/08/2022.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Peron in Charge will have oversight in both locations of the designated centre. A member of the Senior Management Team has been appointed as PPIM for the centre. The local manager/Team Leader in post in one of the locations will now report to the PIC of the designated centre in line with the Organization Structure set out in the centres Statement of Purpose. All unannounced provider audits will ensure to include both properties on the one report.	
Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The required changes were made to the Statement of Purpose and sent to registration on the 29.08.22.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: A retrospective notification for minor injury to a resident was submitted via NF39D on 10/08/2022. Retrospective quarterly notifications were submitted with regard to a locked gate in one location via NF39A. Retrospective quarterly notifications were submitted for the last 4 quarters with regard to physical restraint and environmental restraint in one location via NF39.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Risk assessments for the resident have been reviewed and updated. The risk assessment on safeguarding and lone workers for this resident has been updated	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Service Manager contacted the external Fire Management Company on 10/08/2022 and arranged for servicing of fire extinguishers at one location on the 15.09.22 Fire Management plan has been reviewed and update.	

PEEP for the resident in one location has been updated.
The monthly fire safety audit for one location for July was completed and was not filed correctly in the folder. This has since been signed and filed appropriately.
Wooden box surrounding fire panel in one location has been removed.
Online practical training needs to be provided to staff specific to evacuating from designated centre.

The evacuation of a particular resident from the annex via the bedroom door and garden gate route is no longer applicable as the resident in question moved back to the main part of the respite house on 19/08/2022.
A fire drill will be completed when the room will be occupied by a respite resident. The drill will include evacuation via the bedroom door and garden gate.

The resident's PEEPs were reviewed and updated on 09/09/2022

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Residents Behaviour Support Plan was reviewed and updated to include use of emergency protocol.

Staff are scheduled to attend MAPA training before the 31/10/2022

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 7(3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the designated centre) within 28 days of the change and supply full and satisfactory information in regard to the matters set out in Schedule 3 in respect of any new person participating in the management of the designated centre.	Not Compliant	Orange	09/08/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management	Not Compliant	Orange	10/08/2022

	structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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.	Not Compliant	Orange	10/08/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/10/2022

Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	08/09/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	16/09/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	09/09/2022
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	30/09/2022
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes,	Substantially Compliant	Yellow	31/12/2022

	location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/09/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	09/08/2022
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	Not Compliant	Orange	10/08/2022

	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	10/08/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/10/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	02/09/2022
Regulation	The person in	Substantially	Yellow	02/09/2022

07(5)(c)	charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Compliant		