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:	Beechview House (Orchard)
Name of provider:	Autism Initiatives Ireland Company Limited By Guarantee
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	12 August 2021
Centre ID:	OSV-0002060
Fieldwork ID:	MON-0025767

About the designated centre

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

Beechview House (Orchard) is a designated centre operated by Autism Initiatives Ireland Company Limited. It provides community residential services to up to nine adult residents with an Autism Spectrum Disorder (ACS) and other associated conditions. The centre comprises of three apartments which are attached to each other through internal doors. The provider applied in June 2021 to separate the three apartments into three individual designated centres, Orchard, Oaks and Blossoms. Each apartment consists of an open plan kitchen/living/dining room, utility room and a shared bathroom. Each resident has their own bedroom with en-suite. The centre is situated in a suburban area of County Dublin with access to a variety of local amenities such as shops, train stations, bus routes and the city centre. The centre is staffed by a area manager, team leaders, social care workers and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 - 2015 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 12 August 2021	9:40 am to 5:05 pm	Erin Clarke	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the residents in this centre were supported to enjoy a good quality of life which was respectful of their choices and wishes. The provider and person in charge endeavoured to ensure the delivery of safe care whilst balancing the rights of residents to take appropriate risks. Residents were supported to live as independently as they were capable of. Overall, the inspector found that residents' wellbeing and welfare was maintained by a good standard of evidence-based care and support.

The designated centre provides residential services to adults with an Autism Spectrum Condition (ASC) and other complex needs. The centre was registered for up to nine residents across three ground floor apartments. At the time of the inspection, six adults were supported with full-time care and support, one service user availed of respite four nights a week, and there were two vacancies. The inspector found there were high numbers of staff supporting residents to ensure they were supported in line with their care and support needs and that they have opportunities to engage in activities that they find meaningful. It was evident that every effort was being made to support residents to explore their interests to support them in developing goals.

The inspector had the opportunity to meet with one of the seven residents availing of the service at the time of the inspection. Some residents expressed that they preferred limited engagement with the inspector, and their choice was respected. Other residents were engaged in activities outside of the centre, two residents had taken a day trip to attend a hotel to use the swimming pool facilities that had recently reopened. While another resident was at home with family. A number of residents' planned community-based goals for 2021 had been put on hold due to the current health pandemic restrictions. However, residents were encouraged to engage in other activities that were in line with their interests and were not impacted by the restrictions. Residents gave examples of the activities they enjoyed doing during the lockdown in their questionnaires, including quizzes, bird watching, scrapbooking, using the computer and exercise bicycle.

On arrival at the centre, the inspector met with one resident who gave them a tour of their apartment. They showed the inspector their new sitting room with all their items of interest, including books and DVDs. This sitting room was a recent addition to the centre. The resident's bedroom was split into two rooms to allow the resident to have additional living space to watch television in the evening. The resident informed the inspector they were happy with the new room. The provider had completed these works in response to some compatibility issues regarding noise levels of the television. And as a result, it was reported these incidents had decreased.

Following a walk around the centre, the resident brought the inspector outside to view the garden area. The inspector observed artwork hanging on the walls of the

building, which residents had completed during the lockdown. The inspector noted that a CCTV camera was facing into the garden area from the apartment building and queried its use and potential impact on residents rights. The person in charge confirmed it was not installed by the provider and would they would investigate if the camera was operational. Further information received post-inspection confirmed that the origin of the camera remained unknown; however, it was believed that it was not in use and the inspector would be updated on the outcome.

The inspector observed that residents' needs were well supported through ongoing consultation, reviews with key working staff. For example, they were devising clear and individualised personal plans with residents to pursue their interests, goals, participate in community activities and exercise personal choices. The inspector viewed the minutes of one resident's keyworker meetings. They contained a summary of the items discussed and pictures of the resident engaging in some activities relating to these discussions. For example, there were pictures of them going on a day trip to Wicklow. It was clear from reading residents plans there was a clear requirement for supports to positively address behaviours of concern. Where required, residents had a behaviour support plan to guide staff on how best to support their assessed needs. Behaviour support plans were drawn up by keyworkers and the person in charge who had received additional training in this area. However, improvement was required to ensure they were subject to a suitably professional review. Clinical input, oversight and review of the suitability and effectiveness of behaviour support plans was not evident in the plan reviewed by the inspector.

In addition the inspector identified that the support plans did not adequately address all the residents' needs to provide sufficient guidance for staff, especially from a healthcare perspective. In particular, a healthcare intervention relating to the administration of emergency rescue medicine was unclear as documented and told to the inspector.

The inspector reviewed feedback that families and residents had submitted as part of the provider's annual report consultation process. Overall, the annual review relayed that feedback was positive. Understandably there was an element of frustration with the COVID-19 restrictions that have been in place over the previous 18 months. For example, one resident had become an uncle but had not yet had an opportunity to meet their nephew other than through video chat. Other residents had not been able to visit their families who live overseas or in different parts of the country. Residents were supported to maintain links with family and friends through video calls, window visits and sending care packages. Residents' feedback also focused on the activities they are looking forward to doing when restrictions are lifted, such as getting a massage, going to a music class or the gym. Another resident spoke about the possibility of doing some volunteering. One resident said that they did not enjoy being in the house all that much and found it difficult to stay in for longer periods of time during bad weather. They were hopeful that they could return to their day services and eat in their favourite restaurants soon again.

The inspector received 11 completed resident and family questionnaires that were completed prior to the inspection. Five residents had returned their responses

independently, another resident was supported by staff, and five families posted or emailed their questionnaires back to the service. The questionnaires asked for participant feedback on a number of areas, including general satisfaction with the service being delivered, bedroom accommodation, food and mealtime experience, arrangements for visitors to the centre, personal rights, activities, staffing supports and complaints. There was very positive feedback provided in the completed questionnaires with residents indicating that they were very satisfied with the service they were in receipt of. For example, "I am like a celebrity here", "I can make my own choices, and " I'm treated as an adult". Another resident said they liked to make plans with their housemates and enjoyed their activities in the house. Residents did not have many suggestions regarding any changes they would like, with several stating, " I wouldn't change a thing".

Family members of residents were equally complimentary towards the service and staff support in the centre. Their questionnaires described staff as "happy, welcoming and attentive", with one resident's family member saying staff were very supportive towards residents in achieving their goals. One recommendation was requested relating to the fixed phone lines in the centre and having separate phone numbers. The inspector brought recommendations raised to the person in charge. Families expressed that they believed their family members' emotional wellbeing to be appropriately supported. They understood restrictive practices to be in place for the safety of their family member. The inspector was made aware that the provider was making changes to the restrictive practices approval and oversight systems in response to another inspection's findings, discussed further under quality and safety section.

In their questionnaires, residents indicated that if they were unhappy about anything, they would speak to their keyworker or go to a member of the staff team or the complaints officer. Two residents who had used the complaints process indicated they were happy with how their complaint was dealt with and with the reply they got from the complaints officer. There were no complaints communicated with the inspector on the day of inspection.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

This planned inspection was announced to the provider and person in charge on 15 July 2021. This inspection aimed to gain further information concerning the centre's application for renewal of registration. The inspector found that the care and support provided to the residents was person-centred and promoted an inclusive environment where each of the resident's needs and wishes were taken into account. The provider had ensured that the centre was adequately resourced and

staff were aware of their roles and responsibilities. In relation to the capacity and capability regulations, improvements were required to ensure that the changes in company directors were notified as required, policies were updated in a timely manner, and the statement of purpose contained all of the relevant information.

The provider had applied to change the configuration of the centre and it's governance and management arrangements. Currently, the designated centre consisted of three large ground floor apartments registered for nine residents, linked by connecting locked doors. At the time of inspection, the centre was managed by a person in charge, the area manager, with support from two experienced team leaders in the designated centre. The provider intended to strengthen the governance and monitoring of the centre by splitting the centre into three individual designated centres with it's own management and staff team. The inspector found that the three apartments operated independently with separate rosters, staffing arrangements, and resources, which supported the provider's application to vary the centre without negatively impacting the residents.

At the centre level, the person in charge had good management systems in place to ensure day-to-day oversight of the centre's running. Due to their large remit as area manager, they had delegated duties to the team leaders to carry out tasks on their behalf, including auditing, supervising staff, and administration work. These included fire checks, financial audits, personal plans audits and health and safety checklists. While the current local monitoring systems strived to achieve positive outcomes for residents, the provider had recognised that to ensure appropriate oversight of the designated centre by the person in charge, a review of the person in charge's responsibilities and level of accountability was required. The inspector assessed the two team leaders as incoming persons in charge and found they held the necessary qualifications and experience required by regulation. Both had worked in the centre for some years, were well known to residents, were aware of their needs and the necessary support to meet those needs.

There were a number of quality assurance audits in place to review the delivery of care and support in the centre. These included health and safety, medication management, bi-monthly peer reviews, unannounced night time inspections, six-monthly unannounced provider visits and an annual review for 2020. The provider had responded to a previous inspection's finding whereby the annual review was not centre specific and did not include consultation with residents and their representatives. An action plan was developed due to residents and their families' recommendations, demonstrating that these views were driving improvements in the centre.

The team leaders maintained a planned and actual roster of the shifts worked in the centre. From a review of a sample of rosters, it was evident that there was a sufficient level of staff to meet the assessed needs of the residents, including one to one support where required. Each apartment had an allocated staff team and relief panel, which ensured continuity of care. Throughout the day of inspection, the inspector observed positive interactions between residents and the staff team.

There were effective systems to support staff to carry out their duties to the best of

their abilities. Staff were in receipt of regular formal supervision, occurring six times yearly. Staff who spoke with the inspector were aware of their roles and responsibilities and said they were well supported by other staff team members and management. The provider had a comprehensive training program, and the inspector found significant training and development levels for staff members. Staff spoken with discussed how beneficial the training provided was for them in their roles and the ease in accessing the training. Staff meetings took place on a monthly basis and were resident focused.

Registration Regulation 7: Changes to information supplied for registration purposes

Two changes of directors for the provider had not been notified to the Chief Inspector within the specified time lines.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge had a large managerial responsibility in total at the time of this inspection. Based on the compliance levels of this inspection and the proposed changes to the person in charge, the inspector did not find this arrangement to have a negative impact.

The two incoming persons in charge had professional qualifications in social care and a recognised qualification in management. They were employed on a full-time basis and worked supernumerary to the staffing quota.

Judgment: Compliant

Regulation 15: Staffing

The inspector observed a staff culture in place that promoted and protected the rights and dignity of the residents through person-centred care and support. The number, qualification and skill mix of staff members employed in the designated centre was found to be appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the centre. There were 22 full-time front line equivalent posts in the centre and, while there was one vacancy at the time of inspection, a new staff member was due to commence work the following week. Staff also had to complete a number of 'shadow shifts' in the designated centre before working alone.

A review of staff rosters demonstrated that the designated centre operated at the required staffing levels for the period of two months prior to inspection, and there was evidence of a stable workforce. The staff roster clearly identified the times worked by each person, and staffing arrangements included enough staff to meet the needs of the residents. There were three waking night shifts in place across the three apartments with delegated duties and tasks. In addition, the service maintained a check-in system for night time staff across all of their designated centres as a lone working measure. All residents had one to one staff support from 8 am - 8 pm. Additional staff were rostered from 10 am to 5 pm to support community activities for one resident. In addition, the inspector was informed rosters were flexible to support events important to residents that occurred in the evening.

There was continuity of staffing so that attachments were not disrupted and support and maintenance of relationships were promoted. Where relief staff was required, only staff from a core relief panel, familiar with the residents' needs, were employed. No agency staff were employed in the centre at the time of the inspection as a COVID-19 measure and to ensure residents were supported by familiar staff.

Judgment: Compliant

Regulation 16: Training and staff development

Autism Initiatives, the provider, devised a clear induction pathway for all new staff joining the organisation prior to commencement of employment within the designated centre named Core Skills Training. The Core Skills week entailed the delivery of training in the following areas, safeguarding for vulnerable adults, autism awareness, positive behaviour support, safe handling and administration of medication.

The person in charge informed the inspector that due to the COVID-19 pandemic and restrictions placed upon one to one training, the Core Skills week was reduced to two days, and some training was delivered online as a temporary measure. To supplement the mandatory training above, the provider also had a suite of additional training available to staff to enhance their competencies. These included communication strategies training, keyworker training and 5 point star approach (an approach to supporting behaviours of concern).

On review of the training matrix, all staff were up to date in mandatory training. In addition, a traffic light system was in place, which easily identifies when staff are due refresher training.

The inspector found that staff were also supported in their roles through an effective supervision process. Staff received regular formal supervision to support them to carry out their roles and responsibilities to the best of their abilities. This supervision

was planned and occurred regularly. In addition, staff identified goals that they wished to work on and were supported to further their education if expressed, for example, completing a course in supervisory skills.

Judgment: Compliant

Regulation 22: Insurance

The provider had submitted an insurance contract on application to renew the centre's registration in line with regulations. However, on reviewing the insurance contract, the inspector noted the contract was made out to the provider's British company, listed in Sterling, and did not specify it insured against accidents or injury to residents in the designated centre.

The inspector requested that a revised contract of insurance would be required, during the open meeting of the inspection. An amended insurance contract was furnished and submitted during the inspection with the specified details.

Judgment: Compliant

Regulation 23: Governance and management

The management structure clearly identified the lines of authority and accountability and staff had specific roles and responsibilities. The governance and management systems in place were found to operate to a good standard in this centre. The provider had completed an annual review of 2020 of the quality and safety of care and support and there was evidence to demonstrate that the residents and their families were consulted about the review.

The provider had implemented a system to track HIQA inspection actions to share learning across all of their designated centres. The matrix identified the areas requiring action, the responsible person and the specified timeframe for each action to be completed. This was demonstrated to the inspector when the provider had identified an area for improvement under restrictive practices (related to regulation 7 positive behaviour support) whereby restrictive practices required review. The person in charge informed the inspector that this non-compliance was identified during an inspection in another designated centre, and a committee responsible for the review of restrictive practices was established in response to that inspection.

An unannounced provider visit of the centre had taken place in June 2021 and in addition, unannounced night-time inspections were completed by area managers to monitor the quality of care provided to residents and to ensure continuous quality improvements occurred. These visits includes ensuring staff awareness of health &

safety, emergency and safeguarding procedures, as well as their knowledge of the residents and review of certain documentation.

Furthermore, there was a robust local auditing system in place by the person in charge to evaluate and improve the provision of service and to achieve better outcomes for residents.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

There were written agreements for the provision of service in place in the centre. Improvement was needed in setting out a contract that would fully inform residents of the service they could expect to receive and the fees payable. The inspector identified that one resident was paying privately for a speech and language therapist when this service was outlined in the statement of purpose.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The inspector reviewed the statement of purpose for the proposed reconfiguration of the centre and found that the majority of the information of Schedule 1 was contained within. However, the inspector requested a review of the statement of purpose to include the following:

- The age range and gender of the residents for whom it is intended that accommodation should be provided.
- A description (either in narrative form or a floor plan) of the rooms in the designated centre, including their size and primary function.

In addition, the inspector identified one aspect of the services provided by Autism Initiatives to meet the support and care needs of the residents, as stated in this document, that was not being delivered to residents. This was the provision of speech and language therapy.

Judgment: Not compliant

Regulation 31: Notification of incidents

Overall, notification of incidents were reported to the Chief Inspector in an

appropriate and timely manner however, the inspector found that not all restrictive practices had been included on the necessary quarterly notification.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a clear and accessible complaints procedure in place. The provider had a nominated complaints officers as well as a person responsible for oversight of the complaints process. There were no active complaints at the time of inspection; however, records indicated that residents were supported to make complaints when they chose to do so.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspector found two of the Schedule 5 policies were not reviewed within three years as required or within the review dates set out on the documents, as below. In addition, a policy was found not to be in place for the monitoring and documentation of nutritional intake.

- Provision of behavioural support dated February 2017
- The creation of, access to, retention of, maintenance of and destruction of records. Dated March 2017.

Judgment: Substantially compliant

Quality and safety

The inspector found that the centre provided a spacious and comfortable environment for residents. It was evident that the person in charge and staff were aware of residents' needs and knowledgeable in the care practices required to meet those needs. Good practice was noted in areas such as safeguarding and personal goal setting. However, the inspector found that improvements were warranted to the oversight of behavioural support plans and restrictive practices.

The inspector completed a walk-through of the premises accompanied by a team leader. As previously mentioned, the centre comprises three apartments attached to each other through internal doors. Each apartment consisted of an open plan

kitchen/living/dining room, utility room and a shared bathroom. Each resident had their own bedroom with en-suite, which were decorated in line with the residents' specific preferences. One resident had their own studio style bedroom with living area and a kitchenette. In consultation with the resident the provider had changed the use of the residents living space into an isolation unit in the event of a COVID-19 breakout. The resident was reportedly happy with their new bedroom but it remained their goal to live more independently.

Due to the nature of the residents' needs, there was a strong focus on and requirement for psychological support. The person in charge and staff strived to promote a positive approach in responding to behaviours of concern. The person in charge was a trainer of the positive behaviour support programme and took yearly refreshing training to ensure consistency and appropriateness of their practice. Staff had received up-to-date training in the management of behaviours of concerns. The inspector viewed a sample of residents' assessments and personal plans, they clearly identified proactive and reactive strategies. However, there was a lack of documentary evidence to show clinical oversight from the relevant treating professional.

The statement of purpose set out the services provided, which included, amongst others, autism-specific speech and language therapy. However, the inspector was informed that the speech and language post was currently vacant. One resident was accessing the previously employed speech and language therapist in a private capacity. There was a lack of clarity around how long the resident would be paying for this therapy. This fee was not laid out in the resident's contract of care as required.

The inspector reviewed the fire management arrangements and found the provider ensured that appropriate fire precautions were in place and the person in charge ensured that these precautions were well maintained. The staff team were conducting regular fire drills which indicated that all residents could be evacuated at all times of the day and night.

The registered provider had effective systems in place to prevent and control the potential spread of COVID-19 in the centre and adequate contingency arrangements in case of infection. The centre was visibly clean, and staff were observed adhering to infection prevention and control practices.

Regulation 17: Premises

The premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. It was of sound construction and kept in a good state of repair.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had developed and adapted existing policies and procedures to guide staff practice during the COVID-19 pandemic. Information was readily available in the centre for residents and staff in relation to COVID-19. Temperature checks were taken for staff and residents daily. All three apartments had separate entrances and exits, and staff were working in pods to prevent cross over.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector observed fire safety measures in the designated centre, including detection systems, emergency lights, alarms, fire fighting equipment and signage. A fire specialist attended the centre regularly to service these. A tour of the premises demonstrated that fire compartments were maintained by fire doors that closed when the fire alarm sounded. Staff had received training in fire safety. Fire drills were carried out regularly in different areas of the building. Due to the nature of the centre, located in an apartment block, additional drills also took place due to the fire alarm being activated in other parts of the building. Drill records included a simulated nighttime fire drill when staffing levels were reduced. Fire drill records were comprehensive and included the time frames in which drills were completed and identified where learning and improvements were needed. The inspector noted that residents personal evacuation plans required review to ensure they contained individualised content. However, the inspector was satisfied this was a documentation issue and residents' needs were accounted for and could be quickly evacuated due to the frequency of the drills.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' personal plans and saw that they included an assessment of each resident's health and personal and social care needs. Residents needs were assessed through an 'about me' assessment which identified residents' needs and outlined the supports in place to support them.

Overall, arrangements were in place to meet those needs. This ensured that the supports put in place maximised each resident's personal development in accordance with their wishes, individual needs and choices. The plans were regularly reviewed, and residents, and where appropriate, their family members, were

consulted in the planning and review process of their personal plans. In addition, keyworkers completed detailed monthly reviews of residents' achievements, progress towards goals, expenditures, health appointments, and risk assessments.

Judgment: Compliant

Regulation 6: Health care

The inspector found that the guidance for the healthcare assessment and personal plans required review, as they were not fully reflective of the care and support provided to residents. For example, where medication was prescribed to a resident for the treatment of a specific healthcare need, there was no corresponding health action plan. Some identified health needs were asthma, iron deficiency, bladder and digestive concerns. In addition, the inspector found conflicting information regarding the emergency protocol in response to seizure activity. The inspector raised this with the person in charge, and verbal confirmation was given that this would be rectified and communicated to all staff.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices in the centre. The inspector reviewed the restraint register and found greater oversight was required in the review of restrictions. In addition, clearer operational processes were needed around decisions taken to implement restrictions. It was not always evident what the rationale for their use was. In some cases, the inspector found decisions were based on historically decisions. Therefore, it was not always clear that alternatives had been considered or that the least restrictive practices were being used for the shortest duration. For example, restriction of computer use, removal of sharp knives and locking of a kitchen door. The inspector acknowledged that the provider had planned to address this shortcoming by forming a restrictive practice committee; however, this was not operational at the time of the inspection. The inspector also noted that not all restrictive practices were notified as required to the Chief Inspector in quarterly returns. This was previously actioned on the centre's last inspection.

There were positive behaviour support plans in place for residents who required support to manage their behaviours. The plans reviewed contained appropriate information relating to reactive and proactive strategies to guide staff. However, improvement was needed in this area as the sample of positive behavioural plans examined by the inspector had not formed part of the review process with the

treating professional.

Judgment: Not compliant

Regulation 8: Protection

The inspector reviewed the safeguarding systems in place in the centre and found clearly defined procedures to identify and address any potential safeguarding issues. In addition, the provider had a policy in place that set out the roles and responsibilities of staff to promote and protect residents' safety and welfare.

The inspector was aware of some safeguarding issues currently open in the centre, mainly related to adverse peer-to-peer verbal interactions. However, all adverse incidents were being recorded, reported and responded to by the person in charge. It was also noted there had been a reduction in the number of allegations of abuse following the implementation of the control measures outlined in safeguarding plans.

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 - 2015 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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Beechview House (Orchard) OSV-0002060

Inspection ID: MON-0025767

Date of inspection: 12/08/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

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: • The change of directors has been completed through the NF33A form. Going forward all change in directors will be completed and notified within the 8 week timeframe.	
Regulation 24: Admissions and contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: • Update the contracts of care and include details of how residents can access private therapies should they choose to do so.	
Regulation 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: • SOP of purpose has been updated to include further details in relation to the age range and gender of residents. • Floor plans have been attached to the updated SOP. • Provision of SLT will be removed from the SOP until this position is successfully recruited for and will include details of residents accessing these privately should they	

wish to do so.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • All incidents will be notified in line with regulation 31 to include all restrictive practices as noted in the restrictive practice register in the designated Centre on a quarterly basis as part of the quarterly returns.	
Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • The two policies outlined as out of date will up updated by the end of October • The health and wellbeing policy will be reviewed to include further detail on nutritional intake as per guidance.	
Regulation 6: Health care	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • The health action plans to be reviewed and include an additional section to capture details and actions relating to short and long term illness and any prescribed or emergency medication including asthma, iron deficiency, bladder and digestive concerns. • The epilepsy management plans to be reviewed and updated to include a more detailed response in relation to seizure type, medication administered and calling for an ambulance. All information and details to be communicated to all staff.	
Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A restrictive practice register is currently being implemented and will be reviewed on a quarterly basis by the practice support team. The practice support team currently reviews all incidents and use of restrictions on a monthly basis and all actions are noted	

in the monthly practice report.
• All restrictions currently in place in Beechview House will be reviewed by the area manager and the team leaders and more detail and evidence included to support the rationale for the restriction. Specific restrictions relating to the computer usage and the removal of sharp knives will be reviewed with the psychiatrist to ensure that the least restrictive approach is in place.
• All restrictions as outlined in the restraint register will be notified as part of the quarterly returns.
• All positive behavior support plans will have oversight by the area manager who is a positive behavior support trainer within the organisation and is certified to deliver training in Positive behavior support. All PBS plans are reviewed monthly by the keyworkers and a report is submitted to the area manager on a monthly basis of all incidents in the service.
• When the initial assessment of needs is completed by the transition manager, this report will document if the individual requires clinical oversight in relation to positive behavior support and this be reviewed yearly at the future planning meeting.
All of the above actions will be included in the unannounced audits that are completed on a six monthly basis.

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(4)(a)	The registered provider shall give not less than 8 weeks notice in writing to the chief inspector if any of the following is proposed to take place: (a) where the registered provider is a body corporate (whether a natural person, a company or other corporate body), there will be any change to: (i) the ownership of the body (ii) the identity of its director, manager, secretary, chief executive or any similar officer of the body (iii) the name or address of the body and shall supply full and satisfactory information in regard to the matters set out in	Not Compliant	Orange	09/09/2021

	Schedule 3 in respect of any new person proposed to be registered as a person carrying on the business of the designated centre under (a), (b) or (c).			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Substantially Compliant	Yellow	15/10/2021
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	15/10/2021
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical,	Not Compliant	Orange	31/10/2021

	chemical or environmental restraint was used.			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Substantially Compliant	Yellow	15/10/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	15/10/2021
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	15/10/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical,	Not Compliant	Orange	15/10/2021

	chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			