Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Mixed).

Issued by the Chief Inspector

Name of designated centre:	Dunmanway Residential
Name of provider:	CoAction West Cork CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	20 February 2023
Centre ID:	OSV-0002110
Fieldwork ID:	MON-0030079

About the designated centre

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

Dunmanway Residential consists of a large purpose built single storey building located in a town. The centre provides a respite service for up to six residents of both genders primarily for those between the ages of 0 and 18 although it can support those up to the age of 20 if they are still in their final year of education. The centre supports those with intellectual disabilities. Support to residents is provided by the person in charge, nurses, social care workers and health care assistants. Individual bedrooms are available for residents and other facilities in the centre include bathrooms, a dining area, a kitchen, a living room, a sunroom and staff rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

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
Monday 20 February 2023	09:15hrs to 18:40hrs	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed and from speaking to staff and management, residents who received respite supports in this centre were offered an appropriate service tailored to their individual needs and preferences. While overall, the service provided was seen to be safe and effective this inspection found that some improvements were required. For some non compliance was identified in relation to positive behaviour support and personal plans and not all risk present in the centre had been appropriately identified and mitigated against.

The centre comprised a large purpose-built bungalow that provided respite accommodation for up to six residents at any one time. The centre was located in a town, close to local amenities and residents had access to a secure outdoor area and the use of an adjoining playground. There were no residents present in this centre when this announced inspection took place and the inspector assessed the care and support of residents by speaking with staff and management and reviewing the documentation present in the centre.

Overall, the inspector saw that the centre was well maintained and appropriate to the needs of the residents that stayed there on respite breaks. Some minor issues relating to the premises were identified and there was a plan in place for these works to be completed. Blinds in the main sitting room was seen to be broken and one of these had an unsecured cord that could present a choking hazard. Residents had the use of a secure outdoor back yard area. The inspector was informed that the residents that used this service enjoyed spending time in this area. A trampoline had recently been disposed of as it was broken and a number of the individuals spoken to during the inspection told the inspector that the children that used this centre had enjoyed using this. The inspector was told that there were plans in place to replace this but this had not yet occurred. The inspector was also told that some additional outdoor furniture had been purchased for this area.

An oxygen tank was observed to be stored behind the door of the staff office. This office was where medications, including emergency medications were stored and the location of the oxygen tank could present a hazard or impediment to staff accessing the office to bring these medications with them in the event the centre had to be evacuated due to fire.

The inspector found that the centre was warm, bright and homely and decorated in line with the age profile and needs of residents that used the service. Residents had the use of individual bedrooms, some with adjoining shower and toilet facilities and the doors of each room were personalised with the names of the different residents that usually used them. There were areas where residents could relax apart from the main communal area and meet with visitors in private if required. Numerous item of sensory and play equipment were available to residents and the centre was seen to be accessible throughout to residents who used mobility equipment. Two bedrooms and a bathroom were equipped with overhead hoist facilities, if required.

Residents had access to cooking and laundry facilities. While there were some restrictions in place in this centre for health and safety reasons, these were seen to be considered and put in place in a manner that would have the least impact on residents.

The inspector had an opportunity to meet with a staff member on the day of this inspection and this individual presented a positive overview of the service and the supports provided to residents. They told the inspector that they felt supported by the management team in the centre. The person in charge told the inspector that questionnaires had been provided to residents and their representatives prior to this announced inspection and that family members had been informed that the inspection was being carried out. Family members did not chose to speak with the inspector but some residents and family members had completed the questionnaires in advance of this inspection and the inspector saw that these provided positive feedback on residents' experiences of the centre. For example, some of the responses included statements such as "staff are caring and attentive" and "my child is safe and happy". The annual review also included feedback from parents of residents that used this centre. This feedback indicated that they were very happy with the service provided and also indicated that more frequent offers of respite would be welcomed.

Overall, this inspection found that there was evidence of good compliance with the regulations in this centre and this meant that residents were being afforded safe and person centred services that met their assessed needs. The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The Chief Inspector had been informed of a number of changes in relation to the management of this centre at provider level. While this would have potential to impact on the oversight of this centre, this inspection found that local management systems were in place that ensured that the services provided within the centre were overall safe, consistent and appropriate to residents' needs. Some improvements were required in relation to the timely identification of some risks and the documentation in place around complaints, personal plans, restrictive practices and positive behaviour support in the centre. Some of these issues will be further discussed in the quality and safety section of this report.

The person in charge (PIC) reported to an Assistant Director of Services (ADOS), who in turn reported to the Director of Services (DOS), who reported to the Chief Executive Officer/Board of Management. The person in charge of this centre was present on the day of the inspection. This person had occupied this role for some time and was very familiar with the residents that lived in this centre. They also had

responsibility for home support services with this provider. The inspector had an opportunity to speak at length with this individual throughout the day. The person in charge was seen to maintain good oversight of the centre and informed the inspector that they maintained positive collaborative relationships with residents' representatives.

The inspector also had an opportunity to meet with the DOS and the ADOS during this inspection. The ADOS role was a new role with specific responsibility for designated centres and was intended to provide an additional layer of support to persons in charge. These individuals discussed the arrangements and structures in place to provide oversight of designated centres under their remit and spoke about changes that were occurring to enhance these oversight arrangements, such as the establishment of a new quality committee. They also spoke about the ongoing staff recruitment issues and the efforts that were being made to address this and maintain safe and appropriate staffing levels. Both these individuals presented as knowledgeable about this particular centre and were aware of any ongoing issues that required oversight in the centre.

An annual review had been completed in respect of the centre and this included consultation with residents and their family members. The provider had also arranged for six monthly unannounced visits to the centre to review the care and support provided to residents. It was seen that where issues were identified, action was taken to rectify them and the inspector had sight of the minutes of a meeting between the ADOS and the person in charge to discuss the action plan

The COVID-19 pandemic had impacted the amount of respite being offered to families due to public health restrictions and infection control considerations. Staffing issues had also impacted the service and the service had closed for a period in 2020. The inspector was informed at the time of this inspection that the full range of services previously offered in the centre had resumed. At the time of this inspection fifteen children were availing of respite supports in this centre. Respite services were provided in this centre up to five nights per week and generally between one and four residents occupied the centre at any one time. The majority of respite stays occurred at the weekends but recently the centre had commenced offering midweek respite also.

There was a clear process in place for the allocation of respite and the admission of residents to this centre and this was outlined in the 'Children's Centre based respite policy'. This policy was seen to be due for review. The inspector viewed records relating to meetings held by the respite committee and saw that resident compatibility was an important consideration when allocating respite and that resident groups were reviewed on a regular bases. The information viewed showed that the management team were committed to offering additional respite stays to individuals where possible and that various factors were considered prior to the offer of a respite place, such as the assessed need of the resident and their family circumstances.

Although staffing levels had been an issue in the years previous to this inspection, staffing levels were reported by the person in charge to be good at the time of the

inspection. Some staff vacancies were identified but these were covered by relief staff and were not impacting on the level of service being provided. There were ongoing recruitment efforts at provider level to cover staff vacancies that arose. Staffing levels were determined based on the assessed needs of residents. Generally between two and four staff supported residents by day and a waking and sleepover staff were present overnight. A sample of staff files viewed showed that appropriate vetting procedures were in place for staff.

The inspector spoke with the person in charge about the arrangements in place to supervise staff in this centre and viewed a sample of supervision records, including those for the person in charge, that had been completed in the centre and saw that pertinent issues such as residents needs and staff training were discussed. Staff also took part in development and performance reviews.

Some complaints had been made in respect of the centre. A complaint was viewed in the complaints log in the centre. It was observed that this complaint had been responded to appropriately but not all records relating to the complaint, such as the satisfaction of the complainant or if the complaints process had concluded. It was seen that records relating to another complaint were not available in the complaints log of the centre. The inspector spoke with the director of services, who was also the complaints officer about this and was provided with full details relating to this complaint, which were being maintained elsewhere. Records viewed showed that complaints were responded to and taken seriously and were being managed in line with the providers complaints procedures.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had made an appropriate application to renew the registration of the centre, including payment of the relevant fee.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a suitably qualified and experience person in charge.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had made efforts to ensure that the staffing arrangements in place were appropriate to the the number and assessed needs of the residents when they received a service in this respite centre. Following a recent recruitment drive, staffing levels had increased to allow for a midweek service to be provided in this centre. A sample of staff files viewed were seen to contain the appropriate information as specified by the regulations. A regular core staff team worked in the centre providing continuity of care to residents. A staff rota was maintained in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Training records viewed showed that staff working in this centre had access to appropriate training, including refresher training. The person in charge maintained oversight of the training needs of staff. Formal staff supervisions were taking place.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was maintained in the centre and was made available to the inspector. This contained the required information specified in the regulations. Some minor amendments were required. The inspector brought these to the attention of the person in charge and these were rectified on the day of the inspection.

Judgment: Compliant

Regulation 21: Records

A sample of staff files viewed by the inspector showed that the relevant information and documents to be obtained in respect of staff employed in the centre was present.

Judgment: Compliant

Regulation 22: Insurance

The provider had in place insurance in respect of the designated centre as appropriate.

Judgment: Compliant

Regulation 23: Governance and management

Local management systems in place were providing oversight in this centre. An annual review had been completed and included consultation with family members of residents. Provider six monthly unannounced visits were occurring as appropriate and there was an auditing system in place. These management systems had not identified some ongoing issues in the centre, such as issues with the personal planning process, unidentified restrictive practices and certain risks. The centre had for a period since the previous inspection been closed due to the COVID-19 pandemic and also limited staff resources. At the time of this inspection, staffing levels had improved and the centre was increasing the amount of respite it could offer.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Contracts of care were in place in this centre for residents. A sample viewed had been appropriately signed by a representative of the resident. However, there were no fees or charges outlined in these contracts.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had in place a statement of purpose that contained all of the information as specified in the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all incidents had been reported as required. For example, some restrictions in place in the centre had not been notified to the chief inspector as required.

Judgment: Not compliant

Regulation 34: Complaints procedure

An easy-to-read/visual complaints procedure was on display in a prominent place in the centre. Staff spoken to were aware of their responsibilities in this area. While complaints were seen to be responded to and taken seriously, the complaints log in the centre had not been clearly maintained to include all the required details relating to some complaints that had been made, such as the outcome or satisfaction of the complainant.

Judgment: Substantially compliant

Quality and safety

The wellbeing and welfare of residents was maintained by a good standard of evidence-based care and support. Overall the evidence showed that safe and good quality service in this centre safe and good quality supports were provided to the fifteen residents that availed of respite services in this centre. However, as mentioned previously, some improvements were required in relation to the timely identification of some risks and the documentation in place around personal plans, restrictive practices and positive behaviour support in the centre.

A Risk Management Policy was in place. A risk register was in place to provide for the ongoing identification, monitoring and review of risk and this was seen to be reviewed and updated on a regular basis. This identified the control measures in place to deal with a number of risks within the designated centre. Where incidents occurred these were found to be appropriately recorded and considered. However, some environmental risks had not been previously identified prior to this inspection. Oxygen was available to residents in the event that it was required. Regular checks were completed on the available oxygen. However, the storage of oxygen in the centre required review. An oxygen tank was observed to be stored behind the door of the staff office. This office was where medications, including emergency medications were stored and the location of the oxygen tank could present a hazard or impede staff accessing the office to bring these medications with them in the event the centre had to be evacuated due to fire. There was no risk assessment in

place regarding the storage of oxygen in the centre.

There were some restrictive practices in use in this centre. These were put in place in line with the assessed needs of individual residents and were, for the most part, focused on ensuring that residents were protected from certain risks. For example, a gate in the kitchen was used on occasion during food preparation to restrict access to hot cooking facilities and equipment that might present as a hazard to specific residents. From reviewing documentation present in the centre, the inspector identified some restrictive practices, including the use of physical restraint, that had not been notified to the chief inspector. While logs were in place to record and review some of the restrictions in the centre, not all restrictions were recorded on these logs. This meant that these had not been subject to review from a restrictive practice committee and oversight of these was not being maintained. Staff had received training in the management of potential and actual aggression and refresher training was booked for this in April 2023.

Individualised plans were in place that contained detailed information to guide staff in supporting residents on an ongoing basis. On review of some of these it was seen that person centred planning meetings had not been held with residents and their representatives. The person in charge told the inspector that regular contact was maintained with residents' families and that plans were sent to them to review and input any new information. The inspector noted a call log in a residents file to inform updates to the residents plan. Plans were seen to be in accessible easy-to-read format. An assessment of health, personal and social care needs was viewed for a resident that was dated June 2021, with no evidence that this had been reviewed since that date. Goals were not documented for all residents. Where they were in place for residents, it was noted that these were generally goals related to activities of daily living. The person in charge told the inspector that residents who used this service generally indicated their preferences and goals for their respite stay during the residents meeting that occurred at the beginning of their stay. The inspector had sight of some of records of these meetings and it was seen that residents were offered choices in relation to the their meals and activities during their respite stay.

Personal files viewed by the inspector showed that residents received a comprehensive assessment prior to admission to the centre and there was evidence that residents' healthcare needs were met while they were in the centre. Nursing support was provided if required and the inspector viewed a PEG (percutaneous endoscopic gastrostomy) protocol for a resident that provided appropriate guidance for staff. A staff member met with the inspector during this inspection and was knowledgeable about residents support needs and presented a positive view of a person centred service being provided to residents in the centre.

Positive behaviour support plans were in place for some residents and the inspector had sight of a sample of these. One resident had a behaviour support plan on file dated July 2022 that contained clear guidance from an appropriate professional in relation to the sleeping habits of the resident and how staff should manage this. However, information contained in another document located in a prominent position in the front of this residents file contradicted this guidance. The language in this document was not rights based and did not promote resident autonomy and it

was unclear as to the rationale for this guidance. Similar information to this was also viewed in other documentation in the residents file. On speaking with the management of the centre about this, the inspector was informed that this guidance was developed by staff that knew the resident well and felt this approach worked best for the resident. However, this had not been reviewed or discussed with an appropriate professional or multi-disciplinary team.

The inspector saw that residents in this centre were being appropriately protected from the risk of infectious diseases, including the COVID-19 virus. Staff had undertaken training on infection control measures including training about hand hygiene and the appropriate donning and doffing of PPE. Local contingency plans were in place to deal with an outbreak of an infectious disease and there was regular review and auditing of IPC practice in the centre.

Regulation 12: Personal possessions

Residents had access to appropriate storage for their personal belongings and had access to laundry facilities if required. An inventory of residents possessions was completed during the check in and check out process.

Judgment: Compliant

Regulation 17: Premises

The premises was suitably designed and laid out to meet the aims and objectives of the service and the number and needs of residents intended to be accommodated. The premises was accessible to residents with additional mobility requirements. Overall, the premises was well maintained. The blinds in the sitting room required replacement and this had been identified by the provider prior to the inspection. There was an outdoor space available to residents with a seating area. Some further work was in progress to ensure that the outdoor recreational areas provided are equipped with age-appropriate play and recreational facilities. The provider indicated that a new swing seat had been purchased for the use of residents. Some equipment, such as a trampoline, had been previously available to residents but this had been removed. The provider indicated on the day of the inspection that there was a plan to replace this.

Judgment: Compliant

Regulation 18: Food and nutrition

Food records viewed indicated that residents were provided with a variety and choice of food and drinks in the centre, including snacks and refreshments. Residents with specific nutritional needs were catered for.

Judgment: Compliant

Regulation 20: Information for residents

An appropriate residents guide was in place and this contained all of the relevant information as required

Judgment: Compliant

Regulation 26: Risk management procedures

There were risk management procedures in place in the centre that overall identified and mitigated against risk. However, some improvements in relation to the identification and assessment of some risks were required. For example, there was no risk assessment in place in relation to the storage of oxygen in the centre and a choking risk due to blind cords had not been risk assessed or fully mitigated against

Judgment: Substantially compliant

Regulation 27: Protection against infection

Infection control procedures in place in this centre to protect residents and staff were found to be in line with national guidance. The premises was observed to be clean and appropriate hand washing and hand sanitisation facilities were available. The centre was overall well maintained and appropriate control measures, such as cleaning schedules and Legionairre's flushing were taken to reduce the probability of residents being exposed to infectious agents. There was a local contingency plan in place in the event that residents were suspected or confirmed to have the COVID-19 virus and screening was completed prior to residents attending the service. Appropriate guidance was available to staff.

Judgment: Compliant

Regulation 28: Fire precautions

A previous inspection had found that fire drills were not always occurring as required. The inspector saw records on this inspection that indicated that regular fire drills were taking place and actions identified. The provider had also informed the chief inspector through a recent compliance plan update that a review was due to take place by an external company of all the fire systems in the designated centre including protocols, policies and systems. The storage of oxygen in the centre required review to ensure that it did not present a fire hazard or impede a full and thorough evacuation of the centre in the event of a fire. This has been covered under Regulation 26.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

An assessment of need was completed prior to residents being admitted to this centre. Plans were in an accessible format and provided clear guidance for staff about residents care and support needs. Plans viewed did not include meaningful goals for residents and there was evidence that a structured review of plans, including multidisciplinary and family consultation was not always taking place.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Not all restrictions in place in the centre were being identified and documented and this meant that they were not subject to oversight. Also a positive behaviour support plan in place for a resident had not been updated to reflect the current practice in the centre. For example, there was conflicting information between this plan and a night time routine protocol in place for the resident.

Judgment: Not compliant

Regulation 8: Protection

Staff and management spoken to were clear on their responsibilities in relation to safeguarding in this centre and all staff had taken part in appropriate training in this area. Where incidents of a safeguarding nature had occurred, appropriate action was taken to ensure that residents were protected and that incidents did not reoccur. Resident compatibility was regularly reviewed and considered when

allocating resident groups for specific respite periods.
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 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dunmanway Residential OSV-0002110

Inspection ID: MON-0030079

Date of inspection: 20/02/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: In order to ensure that the 6 monthly unannounced provider inspections identify issues within the Designated Centre, a review of the current auditing system will take place. The review will ensure that concerns pertaining to the safety and quality of care and support within the Designated Centre are identified. Any identified issues will then form part of the Regulation 23 6 monthly unannounced visit report so as a plan can be put in place to address any concerns.	
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: The contracts of care in the designated centre have been amended to ensure they include all the required information. Completed 14/03/2023	
Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Any requirement for interventions that restricts any resident which has been identified with the input of the relevant clinicians will be applied for, discussed by the Restrictive Practices Committee and sanctioned; should it be appropriate to do so.
The Restrictive Practices Committee will ensure oversight over any restrictive intervention that has been sanctioned and ensure they are reviewed.
All approved interventions will be recorded within the designated Centre and notified as required by regulation to the chief inspector.
The Restrictive Practices Committee has agreed to develop SOP's & PPG's to support the staff teams to recognise and follow the required procedures prior to restrictive practices being utilized.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints that are documented in the centre's complaints book will be completed to ensure all of the required details are present. This will be ensured by the PIC and reviewed during the 6 monthly unannounced inspections.

A review of the procedure outlined in the complaints policy will take place. This is to ensure that the procedure for recording complaints is clear, with regards storing the complaint in the centre's book or if there are instances that complaints are stored elsewhere.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A risk assessment will be carried out with regards to the storage of oxygen in the centre. This will be completed in May 2023.

The safety issue with the blind cord was rectified the days after the re-registration inspection. Completed: 2/02/2023

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
A review will take place of the paperwork used in the centre to identify and track progression of the goals that have been set for the residents. This document will identify the review date and will evidence the people who participated in the development of the goals. This will accompanied by a clear process.

A meeting will take place with the staff team in order to ensure that all staff are aware of the process and paperwork.

The PIC and resident's keyworkers will then arrange a schedule of meetings with the residents, their families to discuss goal setting and identify goals.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC and keyworker will meet with the local psychologist in order to discuss the behaviour support plan of a resident. This meeting will ensure the plan reflects the current practice in the house and also, is the most appropriate way to support the resident.

Any requirement for interventions that restricts any resident which has been identified with the input of the relevant clinicians will be applied for, discussed by the Restrictive Practices Committee and sanctioned; should it be appropriate to do so.
The Restrictive Practices Committee will ensure oversight over any restrictive intervention that has been sanctioned and ensure they are reviewed.
All approved interventions will be recorded within the designated Centre and notified as required by regulation to the chief inspector.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/06/2023
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	14/03/2023
Regulation 26(2)	The registered provider shall ensure that there	Substantially Compliant	Yellow	31/05/2023

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	30/06/2023
Regulation	The person in	Not Compliant	Orange	31/08/2023

05(4)(b)	charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.			
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Not Compliant	Orange	31/08/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her	Not Compliant	Orange	31/08/2023

	representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
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.	Not Compliant	Orange	30/06/2023