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:	A Middle Third
Name of provider:	St Michael's House
Address of centre:	Dublin 5
Type of inspection:	Announced
Date of inspection:	21 February 2024
Centre ID:	OSV-0002360
Fieldwork ID:	MON-0034916

About the designated centre

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

A Middle Third is a community based home operated by St. Michael's House. The centre provides residential services for five adults, both male and female, with an intellectual disability. It is situated on the north side of Dublin city close to all the amenities and facilities the city has to offer. The centre is close to public transport links which enable residents to access these amenities and neighbouring areas. The building is a single-storey, five bedroom home with a homely design and layout. Each resident has their own bedroom, one of which is en-suite. There are two shared bathrooms, one with a bath and shower and the other with a shower. The house is fitted with a ceiling hoist to meet residents' needs. The kitchen is accessible and residents are encouraged to get involved with the preparation of meals and snacks. There is a garden to the rear of the property with two sheds for storage. Staff encourage residents to be active members in their communities and to sustain good relationships with their family and friends. The staff team comprises a person in charge, staff nurses, social care staff, direct care support staff and a household staff. Staffing resources are arranged in the centre in line with residents' needs.

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
Wednesday 21 February 2024	09:30hrs to 17:00hrs	Jennifer Deasy	Lead
Thursday 22 February 2024	10:00hrs to 16:00hrs	Jennifer Deasy	Lead
Thursday 22 February 2024	10:00hrs to 16:00hrs	Orla McEvoy	Support

What residents told us and what inspectors observed

This inspection was an announced inspection scheduled to inform the renewal of registration for this designated centre. The inspection was carried out over two days. On the first day, one inspector attended the designated centre and had the opportunity to meet with residents and staff, review some documentation and complete a walk-around of the premises. On the second day, two inspectors attended the provider's office and reviewed a more comprehensive suite of documentation pertaining to the quality and safety of care in the centre.

Overall, inspectors found that residents were in receipt of good quality care which was delivered by well-trained staff in a safe and homely environment. However, there were enhancements required to the oversight of restrictive practices

The designated centre is located in a suburb of Dublin, close to many public amenities. The centre was home to five residents at the time of inspection. The inspector was greeted by the person in charge on arrival. An opening meeting was completed wherein the person in charge outlined actions that the provider had taken within the current regulatory cycle in order to enhance the quality of care in the centre. For example, the provider had completed upkeep to the premises to ensure that the centre was comfortable, accessible and well-maintained. The person in charge also outlined some of the challenges facing the service, including the ongoing difficulty with recruitment of staff. They set out the measures that they had implemented in order to control for the risk of inconsistent staffing and to minimise the impact of this on residents.

All of the residents were in day services when the inspector arrived. On a walk-around of the centre, the inspector saw that it was very clean and well-maintained. It had been fitted with aids and appliances such as hoists and accessible baths and wet-rooms in order to meet residents' assessed needs. Residents in this house each had their own bedroom. Residents' bedrooms were decorated in line with their personal preferences. The inspector saw that care had been taken to ensure that residents' possessions and photographs were displayed and readily available in their bedrooms.

Residents also had access to an accessible bathroom, two sitting rooms, a utility, kitchen and a sensory room. A large garden was accessible to the rear of the house. The furniture and fittings in the centre were clean and well-maintained. Overall, the centre appeared comfortable and homely.

A housekeeping staff member was working in the centre on the day of inspection. They showed the inspector the materials and products that they used to clean the centre. The inspector saw that these were in line with best-practice infection prevention and control (IPC) standards. Since the last inspection of the centre, the provider had supported a staff member to complete specialist IPC training. This staff had taken on the role of the IPC lead for the centre. They showed the inspector the

audits that were completed to control for IPC risks in the centre. They also showed the inspector spills kits that had been implemented in respect of specific risks.

Other staff, spoken with over the course of the inspection, were found to be familiar with the service-specific risks and with the residents' individual needs and preferences. Staff in this centre had received specific training in communication and could describe how they supported residents to make choices and decisions. Staff in this centre were in the process of completing human rights training at the time of inspection. Staff were informed of their safeguarding roles and responsibilities and of the pathways to escalate any concerns regarding the safety and well-being of residents.

In the afternoon, the inspector sat in the dining room and observed the evening meal preparation. Dinner looked and smelled appetising. Staff described the residents' assessed dietary needs including feeding, eating, drinking and swallowing care plans. Staff were well-informed of these care plans and described to the inspector how they modified food in line with residents' assessed needs.

During dinner, the inspector saw that there were gentle and respectful interactions between staff and residents. The inspector saw that staff took care to uphold residents' dignity during meals. For example, residents were asked if they would like to have their hair tied back from their face during meals and were supported to put on clean aprons to protect their clothing if they wished. Specialist cutlery and crockery was also available to those residents who required these.

The inspector had the opportunity to meet all five of the residents in the afternoon of the first day of inspection. Many of the residents communicated through multiple modes of communication including speech, Lámh and objects of reference. Staff spoken with were informed of residents' assessed communication needs and were seen to communicate with residents in line with their care plans. Residents were seen to be comfortable in their home.

One resident assisted with dinner preparation and told the inspector about the activities they had taken part in at day service. Another resident, with support from staff, told the inspector that they had visited their mother and brought them a birthday present earlier in the day. Other residents were seen drinking coffee, relaxing on couches and holding sensory materials. Staff were seen to be responsive to residents' communications. Residents and staff were seen sharing jokes and laughing.

The inspectors did not have an opportunity to meet or speak to family members of the residents. However, the centre's annual report from 2023 demonstrated that family members were very happy with the standard of care in the centre. Family members told the provider that they felt that there was open and effective communication from the staff to them, and that they felt their family members were very well looked after and cared for.

Some improvements in the area of restrictive practices were required. The inspector observed there were a number of restrictive practices implemented in the centre. Information and discussions about these restrictive practices did not fully

demonstrate that they were the least restrictive possible or that their potential impact on the rights of residents had been fully considered. Some of the restrictive practices also had potential to impact on evacuation arrangements in the centre. This required review by the provider and is discussed more in the quality and safety section of the report.

Overall, the inspector saw that residents were in receipt of good-quality care and support which was meeting their assessed needs. Staff in this centre were striving to provide care which was in line with the Regulations and Standards.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided. Overall, the inspectors found that there were effective oversight arrangements which were ensuring that residents were in receipt of good quality and safe care.

On the first day of inspection, the inspector saw that residents were in receipt of care from a familiar and well-trained staff team who knew the residents, their needs and preferences well. However, on review of the roster, it was evident that there was a high reliance on relief and agency staff to fill gaps in the roster due to staff vacancies. The person in charge had put in place arrangements to minimise any potential impact of inconsistent staffing on residents. For example, familiar relief and agency staff were booked where possible. The inspector was told that the provider was endeavouring to fill vacancies and the inspector saw that this was reflected as an action in the provider-level audits.

There were clearly defined management structures in place. Staff spoken with were aware of the reporting arrangements, of their individual responsibilities and of how to escalate risk. There was a high level of compliance with mandatory training and staff had also received additional training in respect of residents' assessed needs. Staff were supported by a local team leader who reported to the person in charge. The person in charge, in turn, reported to a service manager. The person in charge had mechanisms in place to escalate risk and service needs to the provider level.

There was a comprehensive suite of local and provider-level audits which accurately reflected risks in the centre. Action plans were implemented where it was identified that actions were required. These plans were time-bound and were allocated to suitably responsible individuals.

The inspectors reviewed documents which were required to be maintained in line

with the Regulations. These included Schedule 2 files for staff, the directory of residents and the residents' guide. Inspectors saw that these documents were suitably maintained.

Overall, the inspectors were assured that the provider had arrangements in place to ensure that they were informed of the quality and safety of care and that they could respond in a timely manner to any risks or service needs identified.

Regulation 14: Persons in charge

The centre was run by a person in charge who was suitably qualified and experienced. The person in charge had oversight of two designated centres including this centre. The other centre was located a short distance away. There were arrangements in place to support the person in charge in having oversight of both centres including, for example, the appointment of local team leads with specific roles and responsibilities for each of the designated centres. These team leads reported to the person in charge and supported them in fulfilling their regulatory responsibilities.

The person in charge had also implemented a series of local audits which were completed by designated staff who had received additional training. These audits assisted the person in charge in having oversight of the service needs in the centre.

There were systems implemented to ensure that risks to the quality and safety of care were escalated to the provider level by the person in charge, for example, through the use of monthly data reports.

Judgment: Compliant

Regulation 15: Staffing

The inspector saw that there were sufficient staff on duty on the day of inspection to meet the needs of the residents. Staff were knowledgeable regarding residents' assessed needs and preferences.

There were a number of staff vacancies in the centre for which relief and agency staff were required in order to complete the roster. The person in charge had implemented arrangements to endeavour to reduce the impact of inconsistent staffing on residents. For example, familiar agency staff were booked where possible and relief or agency staff were rostered on with regular, familiar staff. An induction checklist was also implemented to ensure that relief staff were briefed on the emergency arrangements for the centre and on residents' needs.

However, a review of the actual roster demonstrated that, in spite of the

arrangements implemented to support continuity of care, there remained a high reliance on relief and agency staff to complete the roster. For example, 21 relief or agency staff were required in January. This required review by the provider to ensure that residents were supported by a consistent staff team.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was generally a high level of compliance with mandatory and refresher training in the centre. Staff had also received training in areas specific to residents' needs, for example in communication and human rights. Staff spoken with were knowledgeable regarding their roles and responsibilities and the assessed needs and preferences of residents.

Staff were in receipt of regular support and supervision through staff meetings and individual support meetings. The inspector reviewed the records of these meetings and saw that they were used to develop and support staff to exercise their professional responsibilities.

Judgment: Compliant

Regulation 19: Directory of residents

The centre had an up-to-date directory of residents which was made available to the inspectors to view. The directory contained some of the required information specified in Schedule 3 of the Regulations. The remaining information was available in residents' files which were located in the designated centre.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured that information and documentation on matters set out in Schedule 2 were maintained and were made available for the inspectors to view. The inspector reviewed a sample of staff records and found that they contained all the required information in line with Schedule 2.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the designated centre. The staff team, team lead and person in charge were aware of their defined roles and responsibilities. There were clear systems in place to identify risks and escalate these to the provider level, through the use of local audits and monthly data reports.

Staff in the centre were performance managed and were supported to exercise their professional and personal responsibilities through staff meetings and staff supervision sessions. The person in charge was also in receipt of regular support and supervision from the service manager.

The provider had also effected a suite of audits including safeguarding audits, IPC audits as well as the required six monthly unannounced visits and annual review of the quality and safety of care. Many of these audits were completed in consultation with key stakeholders including residents, families and staff. The audits identified areas for improvement and action plans were implemented in this regard. The inspector saw that actions were completed in a timely manner.

Judgment: Compliant

Regulation 30: Volunteers

There were no volunteers in this centre. Through a review of the provider's safety statement, the inspector observed that the provider had processes in place for volunteers in line with the regulations.

Judgment: Compliant

Regulation 4: Written policies and procedures

The registered provider had prepared written policies and procedures on the matters set out in Schedule 5. A number of policies had recently reached their review date. These policies included:

- Intimate Care Policy
- Nutrition Policy
- Provision of Information Policy

The inspector was told that these policies were under review by the provider and

that updated versions were expected to be made available to the staff team shortly.

Judgment: Compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived there. Overall, the inspector saw that residents were in receipt of a safe service which was meeting their assessed needs. However, improvements were required to the oversight of restrictive practices to ensure that they were accurately documented, that residents' consent was received and to ensure that they were the least restrictive practice as possible.

The inspector reviewed a sample of residents' files over the course of the inspection. Each file contained an up-to-date individual assessment which clearly set out residents' assessed needs and the supports required to meet those needs. Comprehensive care plans were implemented which were informed by relevant multi-disciplinary professionals. Staff spoken with were informed regarding residents' assessed needs. Staff had also received additional training in order to deliver care in line with residents' needs. For example, staff had received training in communication and feeding, eating, drinking and swallowing (FEDS).

On reviewing residents' files, the inspector noted some residents presented with behaviours for which restrictive practices had been deemed necessary. Some enhancements were required to the oversight of restrictive practices to ensure that they were consistently documented at a local level when they had been used. Additionally, improvements were required to ensure that residents were consulted with regarding restrictive practices which impacted them and that their consent to these was documented. For example, one resident required medication to be delivered in a specific manner which was deemed restrictive. While staff were knowledgeable regarding this resident's communication and how they upheld the resident's right to decline to take their medication, this was not reflected in the associated restrictive practice protocol.

Another restrictive practice posed a risk to the safe evacuation of residents. Key locks had been installed on emergency exit doors in the centre. While staff carried a single key which opened these locks, the inspector was not assured that this was the least restrictive practice possible or that the impact of this on the fire safety arrangements had been adequately assessed.

The premises of the centre was seen to be very clean, warm and well-maintained. The inspector saw that residents were living in a homely environment which provided both private and communal space. There was room for residents to receive visitors if they wished. The centre was operating in line with national standards for infection prevention and control (IPC) in community settings. There were adequate hand hygiene facilities and there were clear guidelines and protocols to guide staff

in the management of IPC risks.

Overall, the inspectors found that residents were living in a homely environment and that their needs were being met in line with their individual assessment and care plans. However, improvements were required to the oversight of restrictive practices.

Regulation 10: Communication

Staff had received communication training in order to support the assessed communication needs of residents. The inspector saw that there were up-to-date communication care plans and guidelines on residents' files which were informed by relevant multi-disciplinary professionals.

Staff were informed of these and spoke confidently regarding the mechanisms they used to support residents to make choices and have control over their daily lives.

The inspector saw staff engaging with residents in line with their assessed communication needs, offering choices and supporting residents to maintain their autonomy. There was ready availability of visual supports throughout the house and the inspector saw residents and staff engaging with and using these during the inspection.

Judgment: Compliant

Regulation 11: Visits

There were no visiting restrictions in the centre. Residents were free to receive visitors in line with their wishes. There was adequate private space in the centre for residents to receive visitors.

Judgment: Compliant

Regulation 17: Premises

The centre was found to be warm, homely and welcoming. Residents each had their own bedroom which was decorated in line with their individual preferences. Residents' personal possessions and photographs were carefully displayed and stored.

Residents also had access to several sitting rooms as well as a kitchen and dining

room, along with other communal spaces. One sitting room had been furnished with sensory lights and equipment for residents to use if they wished. A utility room was available to launder residents' clothes.

There was sufficient storage for residents' personal belongings as well as their required aids and appliances. The centre was designed and laid out in a manner that supported accessibility and was generally well-presented and maintained. Rooms were of a suitable size and layout to meet the needs of the residents.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had prepared a residents' guide which met the requirements of Regulation 20. The residents' guide was written in easy-to-read language and was supported with pictures and photos.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had enhanced their oversight of infection prevention and control (IPC) in the centre within the last regulatory cycle. The inspectors found that the IPC procedures in this centre were in line with national standards. There were clear local operating procedures in place to guide staff in respect of managing centre-specific IPC risks. Staff were informed of these local operating procedures and of how to control for IPC risks.

Regular audits were completed in relation to IPC, for example in areas such as the physical environment of the centre and of hand hygiene. Action plans were implemented to address areas for improvement as identified on these audits.

The centre was equipped with adequate hand hygiene facilities. Specialist equipment such as alginate bags and spills kits were available to control for specific risks.

Cleaning equipment was seen to be stored in a safe and hygienic manner and overall, the centre was seen to be very clean and well-maintained.

Judgment: Compliant

Regulation 28: Fire precautions

The centre had been fitted with an appropriate fire detection system, emergency lighting and fire fighting equipment which were all serviced regularly.

Aids required to support the evacuation of residents with sensory impairments were also in place.

However, there was a risk to the safe evacuation of residents due to the installation of key locks on the emergency exit doors. It was noted however, that all of these locks could be opened by the same key and all staff carried a copy of this key on their person.

While this was a reasonable control measure, it was not demonstrated more fire safety compliant alternatives for example, the use of thumb turn mechanisms and/or door alarms, had been trialled before installing key operated locking mechanisms. This required review by the provider.

Some staff required refresher fire safety training as their training certificates were out-of-date at the time of inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' files on the inspection. It was found that residents' files contained an up-to-date individual assessment which was used to inform comprehensive care plans. Care plans were informed by the relevant multi-disciplinary professionals as required. The care plans detailed supports required to maintain the health and well-being of residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices in place in the designated centre. Many of these restrictive practices had been implemented due to residents' assessed needs and were informed by multi-disciplinary assessments and reports. Many had also been referred to and reviewed by the provider's restrictive practices monitoring group (PAMG). However, there were enhancements required to ensure that residents' were informed of restrictive practices, that their consent was documented

and that their rights were upheld.

For example, some staff described completing nightly checks on residents. The impact of this on residents' privacy had not been assessed and this had not been documented as a restrictive practice. There was also a restrictive practice in place regarding medication administration for one resident. The inspector found, on reviewing the protocol for this restrictive practice and in speaking to staff, that improvements were required to ensure that the residents' communication needs were adequately reflected within this protocol and, in particular, to ensure that the resident's methods of communicating their consent or non-consent were documented.

Additionally, the inspector was not assured that all restrictive practices were also the least restrictive. As set out under regulation 28, a risk was identified whereby a keylock was installed on exit doors due to the needs of one resident. The inspector was not assured that other, less restrictive practices had been trialled before installing this lock. Video monitors were in also place for some residents by night to monitor for seizure activity. The inspector was not assured that other, less-intrusive, methods to monitor for seizure activity had been trialled before implementing video monitors.

Judgment: Not compliant

Regulation 8: Protection

There were procedures in place to ensure that residents were protected from abuse. Staff were up-to-date in mandatory safeguarding training. Staff were knowledgeable regarding their safeguarding roles and responsibilities.

The inspector saw that safeguarding plans were implemented where required and that the control measures in these were comprehensive.

The provider's social work department had completed a safeguarding audit in order to further ensure the safety of care. The garda vetting status of staff was also tracked by the person in charge through monthly data reports to ensure that all staffs' garda vetting status was kept up to date.

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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 30: Volunteers	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for A Middle Third OSV-0002360

Inspection ID: MON-0034916

Date of inspection: 21/02/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: · Ongoing recruitment for vacancies within the DC – all vacancies have been forwarded to the HSE for approval and to offer positions in line with present Recruitment Embargo and Derogation requirements- 30/6/2024 Derogation approval received for Nurse- vacancy and staff identified to fill this post- 30/5/2024 · Ongoing recruitment for CNM2 position with further interviews scheduled for the 15/4/2024 · Consistent use of regular and Familiar agency or relief staff.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: · In Consultation with SMH Fire officer decision taken to maintain a key operated system in 10A Middlethird. Thumb turns could lead to resident absconding and potentially being injured due to an RTA or other injury. Controls in place to prevent a fire from happening and mitigating risks in place to reduce the chances of issues arising that may prevent ease of escape. · Ongoing review of Risk – with Risk assessment and support documentation in place Escalated Monthly to service manager and Quarterly through Organisational risk register. · Restrictive requirement remains under review as per PAMG approval on an annual basis- if this changes then appropriate and proportional action will be taken considering the health, safety and well-being of resident and others in the house. · Residents within the DC- are supported by staff to access and egress the DC- impact letters to PAMG indicating the level of impact on each resident and strategies to minimise submitted- 29/3/2024	

· Unit based fire training with SMH- Fire officer scheduled for the 16/4/2024 all relevant Certification will be available for review following this date

· Guidance in place through 'All about Me' and further review of 'Rights support documentation' to enable staff to support residents in demonstrating their Will and Preference- in the absence of verbal communication- resident is supported to express through actions and engagement with staff. 29/3/2024

· Referral to Technical Services Department- Motion Sensory Alarm fitted to front door in conjunction with key pad – 30/04/2024 - for trial basis – 3months to establish if restriction can be reduced- 30/07/2024

· Restrictive practice log in place and Quarterly notifications sent to regulator

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

· Review of all Residents Rights support plans reflective of clear indicators of the residents communication supports and how they can be supported to exercise their Will and Preference – 29/3/2024

· All staff have completed Total Communication training- 30/4/2023

· 5 Staff have completed Rights Based training with further 5 Staff Scheduled to complete by 30/5/2024

· Review with staff team 12/3/2024 and establishment that Nightly checks are no longer required 12

· Support plans reviewed for 2 residents re; Video monitoring at night due to Seizure activity- Falls risk- and probably sleep disturbance from checking at night- Alternative options have been considered –but do not provide the level of supports residents would require given their medical support needs – 29/3/2024

· Medication Administration guidelines have been reviewed for one resident and is now informed by residents Will and Preference and il line with their Medication support needs 29/3/2024

· In Consultation with SMH Fire officer decision taken to maintain a key operated system in 10A Middlethird. Thumb turns could lead to resident absconding and potentially being injured due to an RTA or other injury. Controls in place to prevent a fire from happening and mitigating risks in place to reduce the chances of issues arising that may prevent ease of escape.

· Referral to Technical Services Department- Motion Sensory Alarm fitted to front door in conjunction with key pad – 30/04/2024- for trial basis – 3months to establish if restriction can be reduced- 30/7/2024

· Restrictive practice log in place and Quarterly notifications sent to regulator

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 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	30/06/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	30/06/2024
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, location of fire alarm call points	Substantially Compliant	Yellow	30/06/2024

	and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
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	30/06/2024
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/06/2024
Regulation 07(5)(c)	The person in 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.	Not Compliant	Orange	30/06/2024