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:	Coastguards
Name of provider:	Health Service Executive
Address of centre:	Louth
Type of inspection:	Unannounced
Date of inspection:	16 December 2022
Centre ID:	OSV-0002567
Fieldwork ID:	MON-0038785

About the designated centre

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

This designated centre can provide residential care and support for up to seven residents with disabilities, both male and female. The centre is a large two-storey house which accommodates six residents downstairs and one resident in a self-contained apartment upstairs. The downstairs accommodation comprises a well-equipped kitchen, a dining room, a utility room, a sunroom, five bedrooms (one of which has an en-suite bathroom) and three communal bathrooms. The apartment upstairs comprises a kitchen and sitting room, a bedroom, a bathroom, a storeroom and an office. There is a garden to the front of the house with a private parking space. To the back of the house, there is a large garden with a patio area. Transport is available to residents so that they can access both community-based facilities and undertake longer trips. There is a full-time person in charge who is supported by a team of nursing staff and healthcare assistants

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Friday 16 December 2022	09:15hrs to 17:00hrs	Eoin O'Byrne	Lead

What residents told us and what inspectors observed

On arrival at the designated centre, the inspector was greeted by one of the residents. The resident said hello to the inspector. The inspector asked the resident if they could let a staff member know they were at the door. A staff member then arrived and greeted the inspector.

The inspector observed the residents' home to be a busy environment and residents were observed to move freely throughout their home. At the time of the inspectors arrival a resident was engaging in loud vocalisation and seeking staff members' attention. The inspector was informed that there was a deficit in the staff team due to illness, and they were operating one staff down. The staff shortage was impacting the regular service provided to the residents and this appeared to be frustrating some residents. The provider did ensure that a replacement staff member was sourced quickly and safe staffing levels were reached.

The inspector had the opportunity to interact with four residents during the inspection. Residents were seen watching tv, engaging in tasks, and listening to music. Residents were also supported to engage in activities outside of their home with staff.

The residents appeared happy in their home and their interactions with the staff team supporting them. The review of information showed residents' health and social care needs had been assessed and that appropriate care plans had been set up. Some of the residents attended day service programmes where as others had individualised programmes in place. There was also evidence of some residents going to stay with their families on a regular basis and other residents being supported to maintain contact with family members.

The review of records and incident reports identified that there had been occasions where residents had impacted negatively upon one another in the past. Many of these incidents were caused by some residents engaging in loud vocalisation or attempted property damage. Some of the residents found such behaviours intimidating. These issues will be discussed in more detail in the quality and safety section of the report.

The inspection found that other areas required review and improvement. For example, the governance and management arrangements were not ensuring that all aspects of the service provided to residents were appropriate. Issues were found with the service's infection prevention and control (IPC) practices, fire containment arrangements, and with the premises. Further issues were identified relating to resident goal setting and the review and management of risks.

In summary, this inspection found that the provider had not ensured that the oversight of the care being provided to the residents was appropriate and compliant with regulations. This is despite a management structure being in place which was

comprised of, a member of the providers senior management, a person in charge and a staff team with several senior staff nurses.

The following two sections of the report present the findings of this inspection about the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This unannounced inspection, was initially scheduled to monitor and inspect the arrangements the provider had made concerning infection prevention and control (IPC) practices. However, the purpose of the inspection was changed to risk-based due to the non compliance's with the regulations and standards identified by the inspector.

While an internal management structure was in place, the inspection found that the existing governance and management arrangements were ineffective and there was a lack of effective oversight. For example, the service provided to residents was not under appropriate review. Throughout the inspection, it was found that the requested information which was to be reviewed to provide evidence of appropriate care delivery and oversight was not readily available and, in some cases, not completed.

Improvements were required relating to the delegation and completion of tasks. For example, IPC practices required review and revision, as did fire containment measures, maintenance of the residents' home and safeguarding measures. The common theme linking the issues was that there was a lack of effective oversight.

Further issues were found when reviewing auditing practices. A schedule of audits were to be completed each month, but the information available for review showed that audits had not been conducted in October or November. In addition, previous audits had identified maintenance issues with the residents' home and these matters had not been addressed on the day of inspection.

Another example of poor oversight was found following the review of IPC audits particularly in relation to arrangements for isolation purposes following residents contracting COVID-19. The audits identified that, a cabin in the garden could be used for residents and could also be used for staff members who displayed symptoms. Having seen the cabin, the inspector was not assured that the cabin was fit for purpose and sought clarity. The inspector spoke with the Director of Nursing who stated they had not been made aware of the arrangements, and a staff nurse stated they were also unaware of these arrangements. This is despite a number of audits identifying the cabin as an isolation unit.

The inspector reviewed the training needs of the staff team supporting the residents. The review found that the provider and person in charge had not ensured

that all staff had completed the required training. This is despite a training needs analysis being in place that identified when staff needed to complete refresher training. The inspector noted that, for the most part, the staff training was up to date, but improvements were still required.

The inspector reviewed previous and current staffing rosters. There was a large staff team in place that comprised staff nurses, care assistants, and agency staff members. The provider had ensured that the number and skill mix of the staff team was appropriate. The review of records found that there had been issues with staff shortages in recent days. On the day of inspection, there was a deficit of one staff at the beginning of the inspection. However, the review of rosters and records found that the provider had ensured that safe staffing levels were maintained in the service.

Overall the inspection found that the oversight of the service provided to residents was not appropriate. Auditing practices employed in the service did not identify all areas that required improvement and were not reflective of practice. Also actions that had been identified had not been addressed.

Regulation 15: Staffing

On the morning of the inspection, the staff team were operating at a deficit of one staff which impacted the service being provided to the group of residents. However, this was rectified on the morning of the inspection and appropriate staffing levels were in place for the remainder of the inspection.

A review of nursing notes also identified that, in recent days a resident had not attended their day service programme due to deficits in staffing numbers.

The inspector notes that a detailed review of current and previous rosters identified that the provider and person in charge had maintained safe staffing levels and that there were systems in place to seek additional staff if required. For example, a replacement staff member was sourced for the remainder of the shift on inspection day.

Judgment: Compliant

Regulation 16: Training and staff development

There were significant delays in sourcing the staff teams training records. Following a review of these, the inspector found that the training needs of the staff team were under review but that some staff members had not completed training when identified.

For example, safeguarding training was outstanding for a staff member, training specific to manage challenging behaviour was outstanding for another staff member and two agency staff members that regularly worked in the service had not completed their IPC training or donning and doffing training.

The inspector notes that there was a large staff team supporting the residents, and the majority of staff had up-to-date training.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspection found that while there was a clearly defined management structure in place led by the person in charge who was supported by a team of staff nurses, improvements were required to ensure that the management structure was effective in delivering a safe, quality service ot residents.

The oversight of the service being provided to the residents was not consistent or effective. For example, information available to staff members regarding IPC practices was not current. There were gaps in the information available, and staff members that spoke with the inspector were unsure of the steps to follow regarding isolation plans.

The review of IPC audits noted that on several occasions, a cabin located in the residents' garden was identified as an isolation area for residents if they declined to isolate. The inspector reviewed the cabin with the Director of Nursing and a staff nurse. Both agreed that this area was not appropriate as an isolation area.

The provider failed to respond to all actions identified in their audits. Deficits were identified in the providers audits however, there had been delays in these being addressed, in particular regarding the residents' home.

The review of information also showed that audits that were scheduled to be completed each month had not been conducted since September.

Judgment: Not compliant

Quality and safety

The provider had ensured that assessments of the residents' health and social care needs had been completed. These had been updated in recent months and reflected the changes in the needs of the group of residents. Evidence also showed that

residents, if required, were supported to access healthcare professionals.

There were, however, discrepancies regarding the setting and completion of social goals for the group of residents. Some residents had been supported to achieve their goals, but no progress had been made for others. Furthermore, the available information for one resident depicted that no goals had been set for the resident despite them being admitted to the service in May of this year.

As mentioned earlier, the review of information found that there were occasions where residents behaviours of concern negatively impacted their peers. Some residents had the potential to engage in loud vocalisations and intimidating behaviours that caused distress for other residents. A review of strategies employed to manage these incidents showed that improvements were required. The strategies were focused on separating residents and moving residents who were distressed to different parts of their home or to engage in activities away from their home. This was inappropriate and was not protecting residents from all forms of abuse. There was also no evidence of compatibility assessments being completed regarding the group of residents, despite there being incidents where residents negatively impacted one another.

The review of the residents’ home found that the provider had improved some areas since the last inspection. However, the provider had again failed to ensure that all aspects of the residents’ home was well maintained. There were painting works required to hallways, and repair to doorways was necessary. These issues detracted from the appearance of the residents’ home. The inspector also found that storage issues were present during the inspection.

From an IPC perspective, the inspection found that there was surface damage to a number of areas, including countertops, which meant that the areas could not be appropriately cleaned. The information for staff members to follow regarding IPC was not up to date, and an outbreak management plan was not available for review. Covid-19 care plans that were on file were not resident-specific and did not identify how to best support each resident. Isolation plans had also not been created for residents.

The provider and person in charge had also failed to ensure that fire containment measures were under regular review. The inspector found issues, but the provider addressed these during the course of the inspection. The inspector also found that, the provider had not demonstrated that they could effectively evacuate all residents and staff members under day and night time circumstances.

Improvements were required to ensure that the provider had appropriate arrangements for the assessment, management and ongoing risk review. A risk register was in place that required updating, and there was evidence that residents' risk assessments had not been updated within the identified six-monthly timeframe.

The inspector noted that there was an effective system in place for the identification, recording and learning from adverse incidents. Incidents were clearly documented, and efforts were being made to reduce them. The inspector looked at a sample of monthly reviews and found that overall there had been a reduction in

adverse incidents in recent months.

In summary, the inspection found that the provider had failed to ensure that the service provided to the residents was appropriate. The issues discussed throughout the inspection relate to poor oversight of practices. There was a need to review the arrangements for the delegation and completion of tasks. The inspector does note that residents' care plans were well maintained and their health needs were being met, but that overall, substantial improvements were required to bring the service back into compliance with the regulations.

Regulation 17: Premises

The previous inspection in January 2021 identified that there were some improvements required to the premises. The inspector notes that works had been addressed. However, the provider had again failed to ensure that all aspects of the residents' home were maintained in a good state of repair. Painting was required in a number of areas, including the main hallway. There was damage to doorways and damage to the walls in the hallway.

The designated centre is a large building, despite this, there were storage issues. For example, in a sitting room identified as the visiting area the inspector found that fruit and vegetables were being stored in the room along with a small fridge. The inspector also found that a small room off the main hallway was being used as a storage area for hoists and a cleaning trolley and was also the changing area for staff. The room was overcrowded and required cleaning.

The inspector also observed that a mop head was on the ground under the main fridge. A staff member informed the inspector that the fridge could sometimes leak. This issue needed to be appropriately addressed from a health and safety perspective.

Judgment: Not compliant

Regulation 26: Risk management procedures

The inspector found that individual risk assessments had been developed for residents. These outlined how to best support residents and reduce risks. The inspector found that these assessments were due to be reviewed six monthly, however, the inspector found that some risk assessments had not been reviewed within the assigned timeframe.

A risk register was devised that captured social and environmental risks. According to the record, this was last updated on the 18.07.22. The inspector found some of the risks listed as active risks were no longer a concern. Some of these risks were

added to the register in 2018 but were not closed off.

The review of information also identified that despite compatibility concerns, the provider had not completed resident compatibility risk assessments for the group of residents. The provider had completed a risk assessment/safeguarding plan. Still, there was a need to review the current mix of residents and the level of impact some residents had upon their peers.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had failed to ensure that IPC practices were appropriate. The inspector asked staff members if there was an outbreak management plan. The inspector was informed that there was not one, and the review of records showed that this was the case. The inspector did find a COVID-19 response folder, but this was not readily available for staff to review. Furthermore, it had not been updated since the 04.01.22. There was, therefore, a lack of relevant information available for staff to follow in the event of an outbreak in the service.

The team of staff nurses completed IPC audits. These were completed weekly. They had identified IPC issues regarding the premises, which had been raised to the provider’s senior management team.

COVID-19 care plans were on file for the residents but were not resident-specific. They did not give information on the residents or how best to support them. The plans also failed to capture the isolation needs of the residents.

As noted earlier, the IPC audits had identified that there were areas that posed IPC risks. These included surface damage to countertops in the kitchen and utility room. Surface damage was also noted to a handrail in one of the bathrooms. The inspector also observed a sharps box being used that had not been dated on opening and did not have the safety cover in situ.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector reviewed the fire containment measures by ensuring that fire doors were closing appropriately. Two doors, including a resident’s bedroom door, were not closing, and the containment measures were therefore ineffective. The staff team were not aware of the issue before this. The director of nursing arranged for maintenance staff to review all doors, and the problems were addressed on the inspection day. However, the provider needed to check fire containment measures

regularly.

Fire drills were being carried out on a regular basis. The inspector reviewed a sample of these and found that the provider had completed fire drills under day and night time circumstances. The inspector studied these and found that the provider had not completed a nighttime fire drill with all residents since the new resident's admission in May of this year. The further review also identified that the new resident had engaged in two drills with a staff member but had yet to partake in a drill with their peers and staff members since their admission. Therefore, there was a need to demonstrate that the provider could safely evacuate all residents and staff under day and night circumstances.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' care and support plans. The review found that the plans had recently been updated and reflected the changing needs of the residents.

There were, however, inconsistencies found regarding social goal setting and completion for residents.

The inspector reviewed three residents' information; one resident had been supported to set and achieve a number of goals, and the second resident had set goals with staff support. Still, there was no evidence to suggest that the goals had progressed in any manner. Despite moving to the service in May of this year, the third resident had not been supported to identify or work towards any goals at the time of the inspection.

Judgment: Substantially compliant

Regulation 6: Health care

The health needs of residents were under review. They had access to appropriate healthcare services on the same basis as others in order to maintain and improve their health status.

Judgment: Compliant

Regulation 8: Protection

The inspector reviewed adverse incidents and found that there had been occasions where residents had expressed that they were afraid in their home due to their peers' behaviour. There were occasions when some residents had engaged in loud vocalisation, intimidating behaviours and property damage. The provider had developed safeguarding plans in response to the issue. The inspector found that the plans outlined how to reduce the impact but did not fully address the issue. More importantly, they did not protect residents from all forms of abuse.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Coastguards OSV-0002567

Inspection ID: MON-0038785

Date of inspection: 16/12/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC will ensure that the training matrix is updated on a regular basis and ensure the training folder is easily accessible by senior staff in the Centre On the day of inspection the training matrix identified that Safeguarding training was outstanding for one staff member since October 2022, the staff member later noted that her training was in date until October 2023. Relevant training confirmation forwarded to the inspector on the 4th of January 2023. The training Matrix has been updated to reflect this. MAPA training is scheduled to take place on 30th Jan 2023 for two staff members whose training is outstanding. On reflection of training records, two Agency staff completed their IPC on 22/04/2021, 19/11/2021 and donning and doffing was completed on 9th Jan 2023. The Infection Control Lead person for the Centre has carried out hand hygiene training with staff in the Centre, this included IPC theory, Hand hygiene and donning and doffing on 09/01/2023. Senior staff nurses have been trained across the service to lead out on all IPC training needs to include theory and practical sessions for all staff, this is a quality initiative for the service to further support compliance in IPC.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: A clearly defined management structure is available in the Centre identifying who is in charge in the absence of the PIC. There is an out of hours manager on call schedule available to all staff in the Centre, contact details for all managers on call are clearly outlined. There is a Staff Nurse identified on the roster daily to lead out on the shift. A daily schedule of duties for all staff on duty has been developed in the Centre, this was discussed and communicated to staff at a meeting held on 12-01-2023. Plans are in place to deliver workshop presentations in February for all CNM2s and Senior Staff Nurses focusing on governance and management, accountability and roles and responsibilities for all areas of service provision. The frequency of team meetings is being reviewed to improve communication between staff grades. Standing agenda items at the team meeting will include IPC, Audits, PCP's, Safeguarding, Staff Training, Policy updates as core matters for discussion. All audits due since September have now been completed and reviewed with the PPIM, there is a schedule of audits available in the Centre and the PIC will ensure these are completed in a timely manner going forward. The ADON will carry out a monthly review of all audits with the PIC to ensure they are reflective of practices in the house, any actions identified in the audits will be reviewed to ensure they are acted on in a timely manner, any outstanding actions will be highlighted and escalated to the DON as appropriate. IPC practices have been reviewed and were communicated to all staff at a staff team meeting on 12/01/2023. Cleaning schedules have been updated to reflect additional cleaning duties at night time to ensure all areas are clean and clutter free. The PIC will carry out a full review of all documentation required in the Centre with all staff to ensure they are familiar with where they are stored and ensure they are readily available to all staff.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Quotes have been received and funding secured for the upgrade of the kitchen and one bathroom in the premises. Painting works will be carried out in the main hallway to include all doors. Works are scheduled to commence once suppliers have agreed a commencement date and schedule of works. Preliminary dates have been received for kitchen works to commence in February.	

The storage issues identified in the visitors' room have now been addressed. The room used as a changing area for staff has been tidied and cleaned and some items moved to long term storage to ensure the room is not overcrowded.

The fridge has been repaired and is no longer leaking. The PIC has updated the weekly cleaning schedule to include an additional cleaning task to the back of the fridge to avoid the leak from happening again.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All Risk Assessments have been reviewed and updated as required. The Risk Register was updated on 09/11/2022 and has subsequently been updated by the PIC on 28/12/2022 to include a commentary of the update. Following review the risk rating of some risks has reduced due to the supports and additional controls in place. Risks which are no longer a concern have been moved from the active section of the register and are now closed.

Compatibility risk Assessments and impact Risk Assessment will be completed. Recommendations if required based on the outcome of the compatibility reviews will be put in place and escalated as required with a business case in line with the protocols of the service to ensure the needs of individual residents are met appropriately.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Covid response plans and outbreak management plan have been reviewed and are in place. The outbreak management plan has been updated to include the most current guidance from HPSC on the Prevention and Management of Outbreaks of Covid and other Respiratory Infections in Residential Care Facilitates.
The Covid response Folder is now located to ensure it is easily accessible and all staff at our team meeting have been informed of the location of the Covid Folder.

All individual Covid Care plans have been updated by the PIC on 03/01/2023.
The PIC has developed a log of all updates which will be shared with staff team ensuring

that any updates that occur in the future will can be clearly noted and shared with all staff.

IPC issues identified from audit completed are being actioned. Quotes have been received and funding secured for the upgrade of the kitchen and one bathroom in the premises. Painting works will be carried out in the main hallway to include all doors. Preliminary dates have been received for kitchen works to commence in February.

A new handrail was installed in one bathroom on 09/01/2023.

The sharps box was collected and risk eliminated.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Since the inspection the defective doors have been adjusted and are closing correctly. Weekly fire door checks are carried out and additional checks will be carried out and documented post any incident of banging doors to ensure effective fire containment measures. An external fire consultant as per a new fire safety contract for 2023 will complete fire doors checks on each visit to the centre. This will in addition to the internal check completed by staff.
Night Fire Drill carried out with all residents on 03/01/2023.All residents were safety evacuated in a timely manner in line with their PEEP's.
Personal Emergency Evacuation Plans all updated on 03/01/2023.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All residents' goals are being reviewed and updated as required. While one resident's goals were not set, her current goal was to transition into the residential setting. The PIC will ensure that this is documented as her goal in her person centred plan.

Key workers have been identified for all residents. A full review will be carried out on all residents' goals to ensure they are set and achieved. The ADON will carry out a full progress review of all PCPs quarterly with the PIC and key workers to ensure consistency in practice by staff in identifying, progressing and achieving meaningful goals for each resident.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Compatibility risk Assessments and impact Risk Assessment will be completed and recommendations put in place and escalated as required to ensure the needs of individual residents are met appropriately.

Safeguarding plans will be monitored and updated to ensure all residents are safe. There is ongoing review of Behavioral Support Plans and the implementation of Pro Active and Reactive Strategies to mitigate behaviors of concern and ensure a safe environment for all residents.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/01/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/04/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority	Not Compliant	Orange	28/02/2023

	and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	12/02/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	12/02/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of	Not Compliant	Orange	09/01/2023

	healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	03/01/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	03/01/2023
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/01/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/06/2023