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:	Liffey 2
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 24
Type of inspection:	Unannounced
Date of inspection:	21 April 2023
Centre ID:	OSV-0002977
Fieldwork ID:	MON-0039701

About the designated centre

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

Liffey 2 respite services offers respite to adults with an intellectual disability in a large town in Co. Dublin. It is part of a large complex and consists of two units on separate floors of the same building. The first unit consists of seven bedrooms, a communal lounge area, a communal dining room with an old style "diner" theme, a communal kitchen, a laundry room, two bathrooms and two staff office areas. For the most part, the bedrooms are single occupancy, however there is the capacity for two of the bedrooms to accommodate a second person in the case of an emergency respite admission. The second unit has six bedrooms, two living areas, a dining area, a small kitchen, a utility room, two staff offices and two bathrooms. The residents are supported 24/7 by a staff team that is comprised of nursing staff, social care workers and healthcare assistants. There are community based facilities and services available for the residents which include Speech and language therapy, occupational therapy, physiotherapy, psychology, and psychiatry. All residents availing of the respite service also attend the day services in the organisation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 21 April 2023	10:30hrs to 17:00hrs	Karen Leen	Lead
Friday 21 April 2023	10:30hrs to 17:00hrs	Erin Clarke	Support

What residents told us and what inspectors observed

This report outlines the findings of an unannounced inspection of this designated centre. The inspection was conducted to assess compliance with the regulations and to assess the implementation of the compliance plan submitted to the Office of The Chief Inspector following an inspection carried out in September 2022. A previous inspection also took place in May of the same year. Both of these inspections found high levels of non-compliance with the regulations mainly relating to the provision of long-term care in the centre.

As identified during these previous inspections, the location and layout of the premises were not intended to meet the long-term accommodation needs of individual residents, having been designed to provide a respite service to adults. The provider acknowledged these concerns at the time of inspection and gave assurances that they were endeavouring to seek a more suitable long-term living arrangement.

Liffey 2 consists of two respite services located in one apartment building in County Dublin. Prior to COVID-19, the six-bed service on the first floor provided respite services to children, and the ground floor provided respite for a maximum of seven adults. During the pandemic restrictions, service provision in this centre ceased for a period of time before reopening on a phased basis. While adult respite services had recommenced, the children's service did not, and one resident had moved into this service who required emergency respite. While this arrangement was intended to be short-term and also be managed through a different management team in another region, extenuating circumstances meant the resident remained living in the centre.

Communication with the provider outside of the inspection process demonstrated the ongoing progress being made towards finding the resident a more suitable home. As outlined in the centre's Statement of Purpose dated February 2023, the provider intended to submit an application to vary to remove this respite service from the designated centre as it was being re-purposed for day service provision once the resident had transitioned.

On the day of this unannounced inspection, the inspectors of social services also met the six residents that were availing of respite in the service on the ground floor. Residents arrived to the centre in the afternoon, having been at their respective day services. The inspectors noted a calm and enjoyable atmosphere in the ground floor respite, with relaxed and friendly communication between residents and each other and residents and staff. Residents were observed playing musical instruments and singing songs with each other and staff. All residents were observed to be comfortable in the presence of staff. However improvements were required in a number of areas such as risk management, fire precautions, staffing and training and development. An urgent action plan was issued to the provider by the Office of the Chief Inspector of Social Services after the inspection in relation to fire safety

and this will be discussed later in the report.

An inspector met with one resident who was living in the respite service permanently for over a year. They explained to the inspector that while they enjoyed living in the centre and liked all the staff, they were looking forward to living somewhere more suitable. The managers gave the inspectors an overview of a transition plan for this resident and acknowledged that a respite service was not designed for full-time living and was not the intention or aim of the service.

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

Capacity and capability

Following the previous inspection, the provider was requested to attend a cautionary meeting in October 2022 on behalf of the Chief Inspector due to continued governance and management failings. The provider had committed to reviewing the governance structure of the centre as inspectors were not satisfied that the governance and management arrangements were ensuring effective and consistent oversight of the quality and safety of the service as a whole. In addition, the provider committed to transitioning a resident to an appropriate residence in line with their needs.

Following this cautionary meeting, the provider appointed a new person in charge of Liffey 2 in November 2022. This person was already employed in a management role in the region and also had responsibility for the management of some other centres, although not in the role of the person in charge. A new person participating in the management (PPIM) of the centre also commenced in November 2022 in the role of assistant director of nursing. The inspectors found this an effective arrangement that facilitated good oversight of the quality and safety of care provided in all parts of the centre. The management team, consisting of the PPIM and Person in charge, meet on a monthly basis, there was a set agenda in place to ensure that all relevant areas of service provision were discussed.

During the previous inspection, it was found that 80% of staff working in the single occupancy service were being provided by an external agency provider. The provider had committed to implementing a new staff team by January 2023 to ensure the resident's needs were being met by familiar and consistent staff. At the time of the inspection, not all posts had been recruited, and there remained an over reliance on agency staff. However, the inspectors found an improvement in the overall staffing structure, especially in relation to permanent staffing. Two nurses, three social care workers and one healthcare assistant had been employed or redeployed by the provider. Two vacancies remained, which were actively being

recruited.

A training matrix was in place for the centre but inspectors found that it was not adequately maintained in a manner that demonstrated the training requirements for staff in the designated centre. The training matrix demonstrated that several staff required mandatory and refresher training in several key areas. These areas included fire precautions, managing behaviour that is challenging, safeguarding and safe administration of medications . The provider had not ensured that relief or agency staff who worked in the centre were suitably trained. For example, one residents personal individual fire evacuation plan required the support of an evacuation aid for the process of safe evacuation. On the day of the inspection two staff on duty had not received training in fire safety or specific training related to the use of the evacuation aid.

Due to the high volume of staff working in one part of the centre, the inspectors requested evidence of the induction process and staff meetings to determine how pertinent information was shared and disseminated among staff. The induction folder had not been updated since the service changed from a children's respite service to a single occupancy service. Staff on shift confirmed this was the folder they used when commencing working in the service. Two induction check sheets had been completed for staff, but these were absent for the majority of staff. As mentioned in the report, the fire evacuation procedures were unclear and were not contained in the induction information folder for staff. Staff meetings also were only held sporadically in the service. No staff meetings had been held in the single occupancy service, and for the respite service, only three staff meetings had occurred in 2022. Attendance at these meetings was low, and from a review of the minutes, detailed minutes were not kept to allow absent staff to review the outcomes of the meetings.

Inspectors found that improvements were required to the oversight and audit of documentation in the centre. Throughout the course of the inspection inspectors sought various records and documents in relation to staffing and the care of residents and found that a number of records were not accessible to the person in charge.Inspectors noted that where records were in place and available, some records were found to be inaccurate or up-to-date with residents' current assessed needs. Some of these inaccuracies could lead to a risk to residents due to the current staff vacancies identified in the centre. For example induction folders for new staff did not contain pertinent information in relation to residents and did not include updated information in relating to residents support needs in the event of an emergency.

Regulation 14: Persons in charge

The inspectors found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the service

to meet its stated purpose, aims and objectives. The person in charge had a clear understanding and vision of the service to be provided and, was supported by the ADON,. They were implementing change management to the operations of the single occupancy service. It was evident that the person in charge was implementing a quality improvement plan to ensure residents received a good service. During the inspection, the inspectors were made aware of the challenges the person in charge found since coming into the post. The person in charge was aware of areas where improvements were required and were actively documenting and escalating concerns.

The person in charge was found to not be in receipt of up-to-date and relevant information in relation to the centre for example up-to-date training records for staff. Details of these were actioned through the provider's six-month unannounced visit as requested by the person in charge. However, this meant that the person in charge was not in receipt of up-to-date information in order to inform the effective administration and operational management of the centre.

Judgment: Substantially compliant

Regulation 15: Staffing

There was a high reliance on agency and relief staff on a weekly basis to cover staff vacancies. Inspectors were informed that there were four whole time equivalent (WTE) staff vacancies at the time of the inspection. The person in charge was endeavouring to provide continuity of care by employing the same agency staff members to cover the vacancies as much as possible. However, due to the number of vacancies and specific support needs for residents this was not always possible. There was a planned roster maintained for the designated centre, however the inspector viewed recent rotas and found that some improvements were required as some of the shift times were unclear and it was not always clear if the shift time had been completed by the assigned staff. The systems in place for the of staff did not support continuity of care for residents and did not ensure that staff providing support were always skilled and trained to cater for individual residents' assessed needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A training matrix was not adequately maintained within the centre in a manner that demonstrated the training requirements for staff.

The training matrix, when reviewed, detailed significant training requirements,

including full training and refreshers courses for staff. There was a poor oversight of training needs for staff members with no training record on file for two full time staff in the designated centre.

Deficits in training, on the day of inspection included:

- Fire Safety: Four staff required training
- Managing behaviour that is challenging: No training was completed by any member of staff. The designated centre provided support to resident with positive behaviour support plan.
- Manual Handling: Four staff required training
- Safeguarding: Two staff required training
- Safe administration of medication (SAMS): four staff required training

Judgment: Not compliant

Regulation 21: Records

Improvements were required with regard to the information governance arrangements top ensure records were appropriately maintained and available as required. For example, rosters were were not accurately maintained. The inspectors found that record management practices obstructed key stakeholders in accessing important and pertinent records. Furthermore, records requested by the inspectors in order to review compliance with the regulations, were not made available. Some records set out in the schedules of the regulations were not made available to the inspectors on the day of inspection; some of these records were not accessible to the person in charge, who has responsibility for obtaining these records under the regulations. For example, the person in charge did not have access to records relating to staff supervision and staff meetings.

Judgment: Not compliant

Regulation 23: Governance and management

Since the previous inspection, the provider had implemented improved systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. There was evidence that the management systems in place to ensuring that the supports provided were safe and appropriate to residents' needs, and they were self-identifying areas of improvement within the service. Where issues had been identified, actions were completed to address these matters.

Management structures ensured clear lines of authority and accountability were now in place. The inspectors met with the ADON, the person in charge and five staff

members over the course of the inspection. Inspectors also reviewed minutes of staff and management meetings, the centre's quality improvement plan, performance reviews, six-month unannounced audits and the induction process for new staff.

Notwithstanding the levels of non-compliance in this centre and weaknesses in some reporting structures, it was evident that recently appointed personnel were identifying and escalating areas of concern and putting in place corrective action. Advanced plans were in place to transfer additional support to the centre to meet residents assessed needs, and a new home had been identified for the resident living in the single occupancy service. This transition was due to occur in the coming weeks. While aspects of the governance systems now in place were strong the inspectors found that there were not effective arrangements in place to support, develop and performance manage all members of the workforce and facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1. The statement of purpose had been reviewed and revised where necessary.

Judgment: Compliant

Quality and safety

Overall, inspectors found that since the previous inspection, the provider had made improvements in terms of the oversight and monitoring of the quality and safety of care and support provided to residents in the centre. However, improvements were required in the area of risk management procedure, positive behaviour supports and fire precautions.

Inspectors found that residents who were in receipt of a respite service in one unit of the centre enjoyed a good quality service. Inspectors reviewed a sample of health care plans and found that residents had access to multidisciplinary support and that healthcare plans were reviewed at regular intervals.

While the premises was found to meet the needs of residents who were availing of respite, one resident who was residing in the centre as an emergency admission discussed with inspectors their wish to move to a more suitable and long term living

arrangement. The provider was in the process of identifying suitable accommodation, however at the time of the inspection there was no transition plan in place.

The second floor of the premises was continuing to have a negative impact on the overall quality of care and support that could be provided to residents due to volume of upkeep and maintenance that was required. The inspectors acknowledge that the provider has an active plan in place with regard to the transition plan for one resident and the providers intention to submit an application to vary to remove this respite service from the designated centre as it was being re-purposed for day service provision once the resident had transitioned.

While the provider had fire precaution measures in place to protect residents and staff from risk of fire, the measures where not effectively implemented throughout the designated centre. The inspectors were not assured that resident living in the second floor of the designated centre could be safely evacuated in the event of a fire. At the time of the inspection the designated centre was using a high volume of agency and relief staff who were untrained in fire event of a fire. A number of fire door where held or propped open and in addition procedures to be followed in the event of fire were not displayed in a prominent place or readily available to guide staff practice. As a result an urgent action plan was issued to the provider after the inspection in relation to Regulation 28 Fire Precautions. This urgent action identified a timeframe for returning it to the Chief Inspector. The provider submitted the urgent action plan in line with the identified timeframe and provided assurances in relation to the steps they had and were going to take to bring Regulations 28 into compliance in a timely manner.

A review of a sample of resident files demonstrated that residents healthcare needs were assessed annually or in line with changes to their current health status. Residents had access to a range of medical and multidisciplinary supports and there was evidence that these supports were accessed when required.

A sample of resident files reviewed identified that positive behaviour supports plans were not not made available to staff in order to implement safe and appropriate practices. Staff present on the day of inspection could not locate positive behaviour support plans for one resident with inspectors requesting a copy from the person in charge. On review of the positive behaviour support plan it was found to have included strategies and de-escalation techniques to guide staff on how to support residents, however their was no evidence that staff had reviewed strategies or techniques in order to support residents. Additionally, it was found that staff had not received training in managing behaviours that challenge.

Regulation 17: Premises

While the provider had carried out significant work on the ground floor apartment

within the designated centre, considerable upkeep and maintenance was required throughout the second floor apartment.

The storage arrangements were not adequate, with inspectors observing a high volume of items stored in rooms within the designated centre.

While premises was found to meet the needs of residents who were availing of respite, one resident who was placed in an emergency admission had stated to inspectors their wish to move to more suitable and long term accommodation.

The inspectors found that one unit of the centre design and layout did not meet the needs of the resident.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were arrangements in place for investigation and learning from incidents and adverse events involving resident. However, inspectors found that appropriate arrangements were not in place to ensure that risk control measures were proportional to the risk identified and that detailed control measures were not assessed and reviewed in an ongoing manner that demonstrated safe practices for staff when supporting residents.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not made adequate arrangements for evacuation, where necessary in the event of fire for all persons in the designated centre. Staff were unclear on the measures required to aid residents to a safe evacuation in the event of a fire.

On the day of the inspection not all staff had received fire training. The provider had failed to ensure that relief and agency staff who were regularly relied on to fill staff vacancies on the roster had received fire training in both fire evacuation and the appropriate use evacuation aids required to ensure safe evacuation of a resident in the event of a fire.

Inspectors observed that some fire doors were propped open instead of using a mechanism which allowed doors to remain open by choice or necessity without

compromising their ability to contain flame and smoke in the event of a fire.

The inspectors acknowledge that the provider outlined a number of responsive steps in relation to fire safety in their urgent action plan response following the inspection. This included the action they had, or planned to take to mitigate the risks associated with the fire safety systems and documentation in the centre.

Judgment: Not compliant

Regulation 6: Health care

A review of a sample of resident files demonstrated that residents had access to a wide range of medical and multidisciplinary supports as required. Residents healthcare needs were assessed on an annual basis and in line with identified changes to assessed needs.

Inspectors viewed a sample of residents' care plans which included guidelines around residents medical needs including epilepsy management.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where appropriate, residents were provided with positive behavioural support plans. These plans included strategies and de-escalation techniques to guide staff on how to support residents, however these plans were not made available to staff in order to implement safe and appropriate practices. Staff have not been trained in managing behaviours that challenge

Judgment: Not 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	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant

Compliance Plan for Liffey 2 OSV-0002977

Inspection ID: MON-0039701

Date of inspection: 21/04/2023

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: The PIC will ensure all documentation that they are required to have access to in line with the regulations will be saved in a shared folder. The local manager will save all relevant and required information in the agreed secure shared folder. 19.06.2023 The PIC will change from current person to a SCL who will be allocated 0.5 WTE on site and will be supported by residential coordinator and local manager 31.07.2023 When the resident moves from the upstairs location, an app to vary will be submitted to reduce the DC to the remaining respite center on the ground floor.30.09.2023	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Roster developed in line with regulations to show actual and planned shifts, clear start and finish times, staff skill mix 19.06.2023 Recruitment is ongoing , we have filled 1 SCW position for the upstairs resident. This leaves 1 HCA vacancy 30.06.2023 The induction process is under review to ensure all new staff and new relief / agency staff are aware of the emergency procedures, residents support needs and escalation procedures if needed 30.06.2023	

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Training needs of all staff are under review. Training schedule in place , deficits have been identified and scheduled for training 30.05.23
Agency has been contacted and they have supplied a list of their mandatory training for staff , they have assured us that all staff must have this training before being sent on shift. We can avail of person specific records as required and will do so for all regular agency staff.

Two staff who require safeguarding will complete by 19.05.2023

Positive behavior training that was scheduled for 25.04.23 has been rescheduled for 14.06.2023

The PIC will link with SLT team to arrange individualized Total Communication training for staff team 30.06.23

Nursing staff have support and availability of additional clinical training from CNM2 in another DC.
1 staff member has received Link IPC training

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
PIC to ensure all records are saved in secure shared folder for SCL and PIC to access.
A review of records and record keeping will be undertaken to identify any gaps and action plan to address same.
All minutes from staff meetings will be typed and shaved in the units shared folder that all staff have access to. Staff will be required to sign off when they have read same.
19.05.2023

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: PIC to change to new SCL allocated 0.5 WTE to the DC. This PIC will be supported by SCL 1WTE and residential coordinator and DON 30.06.23 Team meetings have been scheduled for each month with the option for staff to attend remotely or in person. 19.05.23 There is a schedule for supervisions in place for VP, a schedule has been developed for the upstairs part of the DC (AQ) 19.05.23	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: There is a barrier to renovating the upstairs unit due to the plans to reduce the DC in size. This will be addressed once the current resident has relocated and the app to vary submitted. 31.07.2023	
Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Additional risk assessments are now in place in relation to the residents change in mobility and fire evacuation. 11.05.23	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Since the inspection on 21st April 2023, the provider has rescheduled the Fire evacuation training for the team supporting the resident with recent changes to his mobility. The roster has been reviewed to ensure there is a trained staff on duty to support an evacuation. The PIC has contacted the agency for fire evacuation training records and is awaiting an	

update on same. Agency staff have also been offered the in-service training.

PEEPs has been updated to reflect the changes in mobility for the gentleman whom has returned from hospital and supports identified in the case of an evacuation.

A fire risk assessment has been updated for the gentleman also

The PIC is updating the induction form for the resident to include fire safety information, and a Fire Drill has been scheduled for next week.

Fire order is in place and staff are aware of same.

Following this the PIC will review the resident's mobility weekly and update the PEEPS further as required.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All staff to receive training in PBS on 14.06.2023

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 14(4)	A person may be appointed as person in charge of more than one designated centre if the chief inspector is satisfied that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.	Substantially Compliant	Yellow	31/07/2023
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	30/06/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and	Substantially Compliant	Yellow	30/06/2023

	actual staff rota, showing staff on duty during the day and night and that it is properly maintained.			
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.	Not Compliant	Orange	30/06/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/06/2023
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/07/2023
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	31/07/2023
Regulation 17(4)	The registered provider shall ensure that such	Not Compliant	Orange	31/07/2023

	equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/07/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	30/05/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/06/2023
Regulation 23(1)(c)	The registered provider shall	Substantially Compliant	Yellow	30/06/2023

	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.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	11/05/2023
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.	Not Compliant	Orange	30/06/2023
Regulation 28(2)(b)(ii)	The registered provider shall	Not Compliant	Orange	28/04/2023

	make adequate arrangements for reviewing fire precautions.			
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.	Not Compliant	Red	28/04/2023
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 and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Red	28/04/2023
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	28/04/2023
Regulation 07(1)	The person in charge shall	Not Compliant	Orange	14/06/2023

	ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	14/06/2023
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	14/06/2023