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:	East County Cork 2
Name of provider:	COPE Foundation
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	01 December 2021
Centre ID:	OSV-0003290
Fieldwork ID:	MON-0029780

About the designated centre

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

This is an adult respite service for residents who are in receipt of full-time day services. Residents have an intellectual disability and / or autism. The designated centre can accommodate six residents. The premises is located in a large town adjacent to facilities and amenities. The service has accessibility to a city by road and rail. The designated centre has its own vehicular transport. The premises comprises two semi-detached houses over two floors, which presents as one large house. There is a shared kitchen / dining room and two separate living room spaces. These living spaces allow for residents to pursue separate interests or enjoy quiet time. A wheelchair accessible downstairs bedroom meant that the centre could accommodate one resident with mobility needs, at any one time. A utility room provided laundry services to the residents. This centre did not provide a respite / short breaks service during the COVID-19 pandemic. Instead it was a dedicated isolation unit to be used if and when it was needed.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	0

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 1 December 2021	10:30hrs to 15:55hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

At the time of this inspection this centre was closed. It was clear that planning had begun regarding the reopening of the centre to provide a short breaks service. However sufficient management oversight had not been maintained during the previous 18 months. As a result improvements were required with the regulations and these were identified during this inspection. Work was required to address these issues prior to the resumption of the short breaks service.

As part of the provider's planning regarding the COVID-19 pandemic this centre had been designated for use as an isolation unit, if required. An application had recently been submitted to the Health Information and Quality Authority (HIQA) to resume providing a short breaks / respite service in the centre. A resident had last used this centre for isolation purposes for a one week period in September 2021. Short breaks were last provided in March 2020. Prior to this inspection, the centre was last inspected in January 2020. As the centre was closed, the provider was contacted the previous week to arrange for this inspection to be facilitated.

As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and management staff adhered to these throughout the inspection. On arrival, the inspector was met by the person participating in management. At the time of this inspection they also fulfilled the role of the person in charge due to a temporary period of extended absence. In the course of this inspection the inspector walked around the premises and reviewed some documentation. As the centre was closed, it was not possible to meet with any residents. The most recent annual review of the centre had not involved any consultation with the residents. It was therefore not possible to include the views or experiences of the residents in this report.

The centre was a two-storey, seven bedroom house located in a coastal town in county Cork. There were five bedrooms for residents upstairs and one downstairs. Bedrooms were clean with suitable storage for residents' belongings. The inspector was told about a recent change to the planned staffing in the centre. Previously there had been what was described as 'a house parent' working in the centre. This person began work on a Friday evening and remained in the centre until the following Monday. Management staff informed the inspector that when the centre reopened there would be two staff working in the centre by day and one staff who would remain awake overnight. This change meant that an upstairs room previously used as a staff bedroom was now available. At the time of this inspection it was allocated as an isolation room. However it was being considered whether to use this room for a resident as it was much larger than one of the other bedrooms. The inspector advised that if this change was to take place a new floor plan would need to be submitted to HIQA.

Downstairs, on one side of the house was the staff office and a resident's bedroom. On the other was a large, well-equipped kitchen, a living room and an additional

recreational space, referred to as the music room. When walking around the centre it was noted that some rooms had very little furniture or furnishings. The inspector was informed that this was due to the centre's use as an isolation centre. Later the inspector saw items such as photographs, pictures and soft furnishings stored in the centre. Due to the removal of furniture, walls were visible that were previously hidden. This revealed areas that requiring painting. It was noted in the last inspection of this centre that walls needed to be repainted where fittings and fixtures had been removed. These were still visible on this inspection. Painting was also required in some of the residents' bedrooms.

There was a noticeable draught in the entrance hall of the centre. Management staff followed up on this during the inspection and arranged for the front door be reviewed by maintenance staff. The area around a window in one bedroom also required review to ensure it was suitably sealed. The areas requiring maintenance had not been identified in any of the audits completed in the centre. There had been reference to works required in the outside area, behind the house. It was evident on the day of inspection that this had been followed up and completed.

The inspector was informed that it was hoped to resume providing a short breaks service in the centre in January 2022. The uncertainty regarding the reopening date was due to the ongoing COVID-19 pandemic. It was planned to resume at a reduced level of service. Rather than providing a short breaks service seven days a week it would instead be provided seven days a fortnight. As this service was only available to those attending day services run by the same provider, it was planned that residents would attend in the pods already in place in their day services. Management spoke about the wish to provide a home away from home for residents and were very conscious how much the service was missed.

It was identified that a lot of the documentation in the centre had not been maintained despite the centre continuing to be registered. Documentation reviewed included the centre's most recent annual review and the reports written following unannounced visits to monitor the safety and quality of care and support provided. The inspector also looked at the proposed staff roster, staff training records, the directory of residents, the centre's risk register, COVID-19 information and contingency plans, fire safety documentation, the centre's statement of purpose and guide for residents and a sample of resident's individual files. The findings regarding this documentation review will be discussed in more detail in the next two sections of this report.

These sections present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

As outlined in the opening section of this report, greater governance and management oversight was required to ensure that the centre was continuing to meet the requirements of the regulations throughout its period of registration.

A new person in charge had been appointed to the centre in March 2021. The inspector was informed that due to a previous role, the person in charge had a very good knowledge of this centre and the residents who accessed it.

Planning had begun regarding reopening the centre. Possible resident groupings had been identified. Management outlined the process to be followed in advance of any resident returning to the centre. It was explained that an information form would be sent to residents and their families to get relevant updates and an easy-to-read document would be provided to explain the reopening plans. It was also planned to contact each resident's day service to ensure staff working in this centre had access to relevant, up-to-date information. Management were very conscious of changes to staff working in the centre and had considered how best to support residents with these changes.

There was evidence that one member of the staff team had continued to regularly visit the centre. During these visits they completed some cleaning and maintenance tasks and some audits. The inspector reviewed a number of recent audits completed. These covered areas such as safety, fire safety, medication, cleaning and specific support practices. Not all documentation had been completed in full, including some fire safety checks. Management advised, following consultation with this staff member, that other checks and activities had been completed but were not always documented.

The last annual review was completed in this centre in September 2020, more than one year prior to this inspection. The inspector was informed that it was planned for one to be completed in the week following this inspection. As previously mentioned this review did not provide for consultation with the residents or their representatives, as is required. Consideration was given to a number of areas of service provision as part of this review. And action plan was generated however the actions to be taken and the person responsible were not outlined.

The regulations require that the provider arrange for an unannounced visit to the centre at least once every six months to review the safety and quality of care and support provided in the centre. The two most recent reports written following such visits were reviewed by the inspector. The most recent visit took place in July 2021. It was also noted that only one such visits took place in 2020. The time frames as outlined in the regulations had therefore not been adhered to. Action plans were also developed as part of these reports. There was evidence that these had been progressed.

The proposed staff roster was appropriate to the planned reopening at a reduced capacity. Further review would be required prior to returning a short breaks service available to six residents at any one time, seven days a week. This was also highlighted in the most recent unannounced visits to the centre. The inspector tried to review the training records of the staff team. However at the time of this

inspection, staff had been redeployed to work in other parts of the organisation.

The inspector reviewed the directory of residents. There was evidence that this had been well maintained prior to the closing of the short breaks service in March 2020. However, it had not been updated since and did not include any reference to the resident who had stayed in the centre for a week in September 2021. It was also identified that it was not documented that a resident had been discharged from the short breaks service in March of this year.

The statement of purpose is an important document that sets out information about the centre including the types of service provided, the resident profile, the ethos and governance arrangements and the staffing arrangements. On review, it was noted that in some parts of the document the focus was on relatives and families rather than the residents themselves. The plan to reopen on a phased basis was not reflected in the statement of purpose and not all room descriptions were consistent with the floor plans.

Registration Regulation 8 (1)

The required information was provided as part of the application to vary the registration conditions of this centre. Management were informed that if they wished to proceed with changing an upstairs room to a bedroom for residents revised floor plans would need to be submitted.

Judgment: Compliant

Regulation 15: Staffing

There was suitable staffing in place for the planned reopening at reduced capacity. It was noted that the staffing outlined was not sufficient to provide a full-time service, at full capacity.

Judgment: Compliant

Regulation 19: Directory of residents

The directory of residents had not been maintained and was therefore not up to date. It did not include any information about a resident who had stayed in the centre in September 2021. It also did not reflect that one resident had been discharged from the service following their move to a full-time residential service.

Judgment: Substantially compliant

Regulation 21: Records

Not all records in relation to residents had been accurately maintained. It was identified that not all occasions on which restrictive procedures had been used in respect of a resident were recorded.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management systems in place in the designated centre did not ensure that the service provided was effectively monitored throughout its period of registration. The provider was not implementing the mandatory governance audits in a timely manner. The most recent annual review and unannounced visits to review the quality and safety of care provided in the centre did not take place at the frequency required by the regulations. The annual review did not include consultation with the residents, as is required.

The poor oversight of the systems in place is evidenced by the findings in this inspection in relation to individual assessment and planning, positive behaviour support, notification of the absence of the person in charge, the directory of residents and other areas where a need for improvement was identified. As the centre had only been open to residents for two short periods of time since March 2020 and was closed at the time of this inspection, these findings did not pose a medium to high risk to residents.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to accurately reflect the rooms in the centre and the plan to provide the service at a reduced capacity as part of its reopening plan.

Judgment: Substantially compliant

Regulation 32: Notification of periods when the person in charge is absent

The chief inspector was not notified of the absence of the person in charge within the timelines specified in this regulation.

Judgment: Not compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

Once notified of the absence, HIQA were informed of the procedures and arrangements in place during the absence of the person in charge.

Judgment: Compliant

Quality and safety

Lack of effective oversight resulted in identified that improvements were required in relation to the quality and safety of the service provided in the centre. Although there was evidence that work was underway to prepare for reopening the service, it was not yet at the required standard.

The inspector reviewed a sample of residents' files. Management had identified six potential groups of residents to access the centre in the first month of its reopening. The sample selected was from these groups of residents. There was repeated reference in the internal audits completed to a review of the system of personal plans including healthcare in the centre. On review of the files it was noted that relevant information had been gathered to inform the assessment of residents' needs. Information available to staff included residents' individual preferences, abilities, routines and areas of independence and where supports where required in many areas of day-to-day life. Residents' medical history and healthcare support needs were also outlined. Hospital passports had been completed for some residents. None of the support plans in place were dated. It was therefore difficult to ascertain when they were last reviewed. Records of multidisciplinary reviews were not available for all residents. Those that were available had not been completed in the last 12 months. Up to date personal development plans were not available in residents' files. Further evidence that the files had not been maintained was repeated reference to former staff as residents' current key workers. As outlined previously, management advised that further information gathering, including contact with day services, would take place prior to any resident attending the centre for short breaks. It is therefore likely that this outstanding information would

be received in a timely manner to ensure staff could best support residents in the centre.

In addition to obtaining the most-up-to-date information available other improvements were required regarding residents' individual assessments and plans. When reviewing residents' files it was noted that not all information was consistent with each other. Information documented in multidisciplinary review meetings, person centred plans, hospital passports, and recommendations from allied health professionals were not reflected in the relevant residential support plan. For example, it was specified that one resident required their food to be prepared in bite size pieces however this was not included in their mealtime support plan. On review of the intimate and personal care plans in place for residents it was noted that the guidance for staff was very vague. Rather than documenting how best to support residents in a personalised and individual manner, the level of support was noted, for example 'full assistance', 'supervision' or 'independent'. Given this was an identified challenging activity for at least one resident, more individualised guidance for staff was required. Some of the residents who accessed the service were non-verbal communicators. Despite this identified need, there was no evidence of input from speech and language therapists in the selection of files reviewed.

On review of one resident's file, it was identified that a routine restrictive practice was in place whenever they spent time in the centre. This had never been notified to HIQA, as is required by the regulations. It was also not included on the restrictive practices register of the centre meaning its use in the centre was not reviewed. Despite an identified need, there was no behaviour support plan available in this resident's file. During the inspection, management contacted the resident's day service and arranged for an up-to-date copy to be sent to the centre immediately.

The inspector reviewed the fire safety systems in place in the centre. It was noted that the alarm system and other firefighting equipment had continued to be serviced consistently throughout the time that the centre was closed. A staff member was also regularly completing some fire safety checks. This did not include all equipment, such as the door releases and extinguishers. The escape routes were not documented in the centre. There were large double doors in the kitchen which led directly to an outside area. It was not clear if these were to be used in the event of a fire as there was no signs to indicate their use. Management advised that they would follow up on this as a priority.

When the centre was open there was evidence that regular fire drills had been completed. This included drills completed in night-time conditions. It was documented that one resident had refused to leave during a night-time evacuation in the past. This was noted on their personal emergency evacuation plan which also outlined how best for staff to support them to leave the centre.

A COVID-19 folder was available in the centre. A self-assessment had been completed to inform the development of a COVID-19 contingency plan. This plan required further review to ensure it was specific to the centre. Management advised that they planned to consult with the staff team to further develop and add more detail to the plan. The folder also included a document, dated June 2020, that

outlined the infection prevention and control protocols to be implemented during the centre's closure. These protocols were not being implemented at the time of this inspection. There were supplies of personal protective equipment available in the centre. Equipment and supplies were also available to facilitate regular hand washing and sanitising.

The risk register had been recently reviewed. It was identified that further review was required to do ensure that the risk ratings were reflective of the risk posed by the hazards identified in the centre. Not all hazards had been identified including the storage of oxygen and the risk posed by one resident refusing to evacuate during a night time drill.

Regulation 17: Premises

Not all parts of the centre were in a good state of repair internally. Some furniture was observed to be torn and painting was required throughout the house. Parts of the centre were very cold due to a draft from the front door. This and an area around the window in one bedroom required review.

Judgment: Substantially compliant

Regulation 20: Information for residents

The guide prepared for residents met all the requirements of this regulation.

Judgment: Compliant

Regulation 26: Risk management procedures

Not all hazards in the centre had been identified. These included the storage of oxygen in the centre and one resident's refusal to evacuate during a night-time fire drill. As a result the risks associated with them had not been assessed. The ratings of the impact of some hazards also required review to ensure they were accurate.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The COVID-19 outbreak contingency plan in place was not detailed or specific enough to this setting. The documented infection prevention and control procedure to be implemented when the centre was closed was not being implemented.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The escape routes were not clearly documented in the centre. The checks regarding some of the fire safety equipment in the centre had not been completed by staff.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Although it was planned to access up-to-date information prior to residents' returning to the centre, at the time of this inspection, residents did not have a current, documented personal development plan. Residents' support plans had not been reviewed in the last 12 months and there was no evidence that recent multidisciplinary reviews of plans had been completed, as is required. Some of the information included in plans, for example intimate and personal care plans, did not identify individual needs or outline how staff could best provide support. It was also noted that plans did not reflect information gathered, as part of the assessment of residents' needs, from a variety of sources including the personal planning process, multidisciplinary reviews, allied heath professional recommendations or hospital passports. As the centre was closed at the time of this inspection these issues did not pose a medium or high risk to residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

A restrictive procedure was implemented in the centre without following the provider's own policies and processes. It was not included on the centre's restraint register and therefore had not been monitored, supervised and reviewed. A behaviour support plan was not available in the centre for a resident who required staff support in this area. This was sourced before the close of this inspection.

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	
Registration Regulation 8 (1)	Compliant
Regulation 15: Staffing	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for East County Cork 2 OSV-0003290

Inspection ID: MON-0029780

Date of inspection: 01/12/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Directory of residents is available when requested and is now up to date to include the admission in September 2020. The PIC will ensure that all information within the directory of residents is maintained and correct.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The PIC makes sure that all records are secure but easily retrievable, all residents have access to their own records. At present records are being reviewed to make sure they are accurate and up to date before any residents return to the premises. Staff are liaising with the person, day services and MDT to bring personal records up to date before the service reopens.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

With the submission of the NF30B the management structure is clearly identified. An annual review of quality and safety has taken place since the visit (02/12/2021), as the centre remains closed, it will not be until the next review that the opinions of residents and staff can be sought, this review will be available to residents on their return. The PIC will ensure that documents are kept up to date.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The statement of purpose is in place and includes all information set out in associated schedule. The statement of purpose has been reviewed and updated in accordance with information about reopening and so that it accurately reflects the rooms. A copy of the statement of purpose is available to residents and their representatives on their return to the centre.

Regulation 32: Notification of periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent: The Chief Inspector was not notified in the required timeframe of the absence of the PIC, a temporary PIC is in place and the relevant NF30B has been submitted to the chief inspector. The chief inspector will be notified within three days of the return of the person in charge.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: The design and layout of the centre are in line with the statement of purpose. There is adequate private and communal accommodation. Residents can access and use the available space both within the centre and garden without restrictions. All relevant maintenance and repair works have been submitted and are expected to be completed before the centre reopens.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC ensures to provide safe appropriate care and support in a safe environment that residents can use. The safety of residents is promoted through risk assessment, learning from adverse events and the implementation of policies and procedures designed to protect residents. There is a comprehensive risk register in the centre which is available to all residents. This register has been reviewed and updated to reflect its shortcomings.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The physical environment, facilities and resources are managed to minimise the risk of residents, staff and visitors acquiring a HCAI. Hand hygiene practices that prevent, control and reduce the risk of the spread of HCAIs are in place. HCAI and communicable/transmissible disease outbreaks are managed and controlled in a timely, efficient and effective manner in order to reduce and control the spread of HCAIs. A more detailed contingency plan is now in place for the reopening of the centre to take place. A sign in sheet for staff who are continuing to carry out

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Suitable fire equipment is provided and serviced when required. There is a procedure for the safe evacuation of residents and staff in the event of fire. Residents are involved in fire drills whenever possible, staff know what to do in the event of a fire. A request has been submitted for a review in relation to fire and all exits in use. This will be complete before reopening. Fire documents are now being kept up to date while the centre is closed.

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: Residents support plans are in the process of being reviewed, taking into consideration the centre is reopening on a phased basis, so that people who are a priority 1 and 2 have been identified and their support plans are being prioritized to update first. This plan will reflect the resident's needs, to maximise the resident's personal development in accordance with their wishes and reflect any change in need since they were last in the centre. Staff are liaising with the people, day services and MDT to have to most current information I their support plan on their return to the centre.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The rights restrictive register is being updated and reviewed in accordance with the registered providers most up to date policy. Any people who have positive behavior support plans, the PIC in conjunction with the day service have the most up to date PBS plan in the person's support plan. This is reviewed annually by the positive behavior support therapist. On recommencement of training staff will be offered the opportunity to participate in Positive behavior support training, staff will comply with all mandatory training schedules	

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 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.	Substantially Compliant	Yellow	13/02/2022
Regulation 19(1)	The registered provider shall establish and maintain a directory of residents in the designated centre.	Substantially Compliant	Yellow	14/01/2022
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that	Substantially Compliant	Yellow	14/01/2022

	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 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/12/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/06/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on	Substantially Compliant	Yellow	30/12/2021

	the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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	14/01/2022
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 healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	31/01/2022
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are	Substantially Compliant	Yellow	14/02/2022

	displayed in a prominent place and/or are readily available as appropriate in the designated centre.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/01/2022
Regulation 32(3)	Where the person in charge is absent from the designated centre as a result of an emergency or unanticipated event, the registered provider shall, as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more, give notice in writing to the chief inspector of the absence, including the information referred to in paragraph (2).	Not Compliant	Orange	14/01/2022
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in	Substantially Compliant	Yellow	31/01/2022

	need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	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 reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/01/2022
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	31/01/2022
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	31/01/2022

Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/01/2022
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/01/2022
Regulation 07(1)	The person in charge shall 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.	Substantially Compliant	Yellow	30/06/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive	Substantially Compliant	Yellow	31/01/2022

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