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:	Glen 3
Name of provider:	Avista CLG
Address of centre:	Dublin 20
Type of inspection:	Unannounced
Date of inspection:	15 December 2021
Centre ID:	OSV-0003727
Fieldwork ID:	MON-0034563

About the designated centre

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

The designated centre consists of three bungalows located in a campus setting and provides a residential service for up to 16 residents who have an intellectual disability and require moderate to high support interventions. The centre is located in a suburb of Co. Dublin with access to a variety of local amenities. Residents are supported 24 hours a day by a team comprising of a person in charge, clinical nurse manager, staff nurses, social care workers, healthcare assistants and household staff. Residents are supported to engage in a range of activities which were meaningful to them both in the community and on the campus where the centre was located. The houses in the centre are purpose built and there is a living room, shared dining and kitchen area, a smaller sitting room, two bathrooms, an office and staff room, laundry room and attic space for storage. Each resident had their own bedroom which was decorated in line with their individual preferences and needs. One resident has their own apartment, attached to one of the bungalows by an adjoining door. Each house has a shared garden and patio area which leads on to the main campus gardens.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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 15 December 2021	09:30hrs to 16:20hrs	Erin Clarke	Lead
Wednesday 15 December 2021	09:30hrs to 16:20hrs	Marie Byrne	Support

What residents told us and what inspectors observed

The designated centre consists of three bungalows located in a campus setting and provides a residential service for up to 16 residents. One inspector had an opportunity to meet three residents in one bungalow and one resident in a second bungalow. The second inspector met with five residents in the third bungalow.

On arrival, one resident greeted the inspector and offered to show them around their home. They brought the inspector straight to the living room to show them their Christmas tree and all the presents under it. They then showed them the garden which had recently had some work done including two new raised beds, and then to their bedroom where they showed them all their favourite possessions.

Another resident then showed the inspector their bedroom and their new family tree and photos. They spent some time in their room and then went out for a walk with staff. A third resident then showed the inspector around their apartment. One resident was relaxing in the living room and another resident was spending time in the multi-sensory room. Each of the five residents appeared comfortable and content in their home, and one resident told the inspector they were happy and that staff were good to them. Residents' bedrooms were personalised to suit their tastes and each of the houses were found to be warm, clean and comfortable. There were Christmas decorations in the houses and on the exterior of the houses

There was a calm and relaxed atmosphere in the house and residents appeared comfortable in the presence of staff and were observed to approach staff should they require any support. Staff were observed to responsive to resident's requests for support and to pick up on their non-verbal cues and to respond appropriately. Staff who spoke with the inspector were familiar with residents' care and support needs and their preferred methods of communication. In another house a resident also showed the inspector their bedroom and took out their computer tablet to play some of their favourite songs and gave the inspector a picture of their favourite singers. They took their computer tablet to a separate sitting rooms where other residents were relaxing so they could listen to their songs.

A staff member talked an inspector through a residents' new person centred plan which celebrated their talents and skills, their goals, their hopes and dreams and they activities they found meaningful. There were pictures of them enjoying some of these activities. It also outlined what a good day looks like for the resident and what is important to them. The inspectors were made aware that the opportunities for residents to engage in more activities outside of the centre was being reviewed and prioritised.

In one of the houses residents had just got a new system which projected fun games, physical, sensory and social games onto the dining room table from a projector coming down from the ceiling. Staff spoke about the games increasing

resident's opportunities for social interaction, fun and physical activity.

In one of the houses there was fruit, snacks and jugs of juice available for residents should they wish to have them between meal times. One resident had a late breakfast and there lunch was being kept warm for them. Staff showed the inspector alternatives should they choose not to have this pre-prepared meal, such as eggs, rice, pasta, sauces and frozen foods. There was a budget for each of the houses to buy these alternatives to ensure there were choices available for residents should they choose not to have the meals delivered by central catering on the campus. In another house one resident was being supported by a staff member to have a snack. The inspectors identified that improvements had been made to the provision of meals to residents with further developments planned by the provider.

There were picture rosters in the houses and folders available for residents with easy-to-read documents on areas such as the availability of advocacy services, COVID-19, safeguarding, complaints, and visitors. There is an advocacy group on the campus and representatives from the houses sitting on this group. The latest minutes were available for residents in an easy-to-read format and the new human rights officer in the organisation had attended the last meeting to introduce themselves and their role. Discussions were held about Christmas celebrations and plans, the charter of rights, COVID-19, new staff in the organisation, and the suggestion box.

The inspectors spoke with several staff on the day of inspection. Staff reported that there was enhanced oversight of the designated centre, with management being more present and more easily available when required. Staff also reported that they had received training in several mandatory and additional areas since the last inspection.

For the most part, the provider had made improvements that affected the residents' lived experiences in the centre. However, there continued to be additional progress required in areas relating to residents rights, positive behaviour support, risk management and the reviewing of the assessed needs of residents. The next two sections of the report will 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 provided.

Capacity and capability

The previous inspection of this designated centre, which took place in August 2021, found significant non-compliance in areas including governance, food and nutrition, staffing, safeguarding, and the promotion of residents rights. Due to the provider's failure to demonstrate the ability to maintain a satisfactory level of compliance, the Chief Inspector proposed to refuse the provider's application to renew the centre's registration. The provider responded with a detailed representation explaining the steps they planned to take to bring the centre into compliance. As a result, the

centres' registration renewal decision was delayed until after a subsequent inspection to determine the level of progress made by the provider to address the failings identified.

This inspection aimed to determine whether or not the provider has completed the actions outlined in their representation, what effect this has had on the centre's compliance levels and the residents' lived experience. Overall, there was evidence to demonstrate that the provider had taken measures to enhance the oversight of the designated centre and address non-compliances. While not all aspects of the representation and service improvement plan were completed on time, the inspectors acknowledged that this was due to the delay of some measures for successful change management. The service manager had devised a priority plan for 2022, which included compatibility assessments for residents, the provision of supports to guide staff through the changes, rights promotion, restriction practice reductions, and commencement of cultural training in liaison with the quality and risk department.

An important component of the provider's response was establishing a governance group comprising individuals from the organisation's executive team to oversee the implementation of quality improvement plans. The inspectors found that the group had been created and had been meeting regularly since forming to analyse the progress of the centre and determine whether specific actions had been achieved. The group's monitoring activities provided far better levels of oversight than previously found, and it was also highlighted how the group connected directly with residents, their family members and staff.

Since the August 2021 inspection, a number of notable changes had occurred, including a change in the person in charge and the service manager. The provider had made some changes to the management arrangements on campus. An established person in charge had been transferred to the centre from another centre on campus to provide expertise and stabilise the governance structures. This was especially significant given that the centre had been without a properly appointed person in charge for over a year due to challenges in hiring and maintaining the position. The inspectors were also informed of the campus's overarching governance structure, which included three designated centres and ensured that resources removed from these areas were replaced. The inspectors found that the person in charge (clinical nurse manager 2) and the service manager had recognised that further improvements were required, additional to those identified in the previous inspection, demonstrating that the monitoring systems in place were now effectively identifying areas of concern.

The provider had performed an analysis of the training needs of its employees and had devised a new training matrix. This training matrix now clearly identified the mandatory training requirements for staff working in each bungalow, compared to records reviewed on the previous inspection. The log also clearly stated the due dates for refresher training and supplementary training needed as determined by residents' assessed needs. The person in charge identified that additional training was required in other areas, including dysphagia, dementia and epilepsy, and had been prioritised for 2022. A review of the supervision process had taken place, and a

schedule was in place for all staff. Additionally, the quality team had met with all staff individually to discuss the findings from the previous inspection as a means of providing additional support to staff. Staff spoke to the inspectors about the changes since the previous inspection and that they were happy with the extra support.

At the time of inspection, the centre had 2.5 whole-time equivalent (WTE) nursing vacancies. The inspectors were informed that an intensive recruitment campaign for these posts was underway, and that interviews would take place the following week. As part of the provider's compliance plan, residents' support arrangements during staff breaks were revised to ensure that residents had adequate continuous support during these times.

Regulation 14: Persons in charge

A dedicated person in charge had been appointed in the designated centre. It was evident that this person held the necessary skills and qualifications to fulfil the role. They were engaged in the governance, operational management and administration of the centre and were present in the centre on a regular and consistent basis. They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process.

Judgment: Compliant

Regulation 15: Staffing

Overall, the staffing arrangements provided were in keeping with the needs of the residents living in the centre at the time of inspection. There were some staff vacancies although efforts were being made to fill these with regular relief and agency staff. Staff rosters were available in the designated centre, but the actual rosters' maintenance needed some improvement. On review of the rosters, parts were ineligible when changes were made to the planned roster.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspectors reviewed the training records on the day of the inspection and found that most staff were now up-to-date in mandatory training. Additionally, in-person bespoke training in managing behaviours of concern and safeguarding had been delivered. Staff reported to the inspectors that they found this training informative

and enhanced the care they provided to residents. The provider was aware there were gaps in the mandatory and supplementary training, which would be rolled out in 2022; however, dates had not been scheduled at the time of the inspection. In addition to providing staff members with training, arrangements were also in place for staff to receive formal supervision on a regular basis.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the poor findings from the previous inspection and the proposed decision to refuse the renewal of registration, the provider established a governance and oversight team comprising of members of the executive and management team to address and oversee the implementation of the plan to address areas of non-compliance and ensure delivery of person-centred supports to residents of a high quality. The inspectors found this strengthened governance structure was successful in increasing the provider's oversight and knowledge of issues that faced the designated centre. For example, the recent six-monthly audit and unannounced visit undertaken by the newly appointed service manager had accurately identified areas for improvement, and an action plan was developed to address those deficits. There was evidence that regular quality walkabouts were also occurring by an executive team member, with actions feeding into the overall quality improvement for the centre.

As previously mentioned, not all actions submitted by the provider were completed within the supplied timeframes, and the monitoring systems in place had identified other areas for improvement to ensure that the service provided is person-centred and appropriate to residents' needs.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The Chief inspector was notified in relation to incidents occurring in the centre, in line with the requirement of the Regulations.

Judgment: Compliant

Quality and safety

Since the previous inspection, there had been improvements in the area of fire safety measures while appropriate safeguarding practices were being followed. In addition, the inspectors found the increased provider oversight had a positive impact on the level of the quality and safety of care for residents. The inspectors observed that the provider was in the process of taking measures to come into compliance. However, further improvements were required in regards to, residents rights, positive behaviour support, risk management and the reviewing of the assessed needs of residents.

Inspectors found that there was improved oversight of restrictive practices in the centre. There was a restrictive practice register, and physical, environmental and rights restrictions were being recognised, recorded and regularly reviewed. High levels of restrictions remained in the centre, and there were a number of restrictive practice reduction plans in place. Some of these risk-reduction plans were in the early stages, and staff were logging times when they were reduced to measure the impact for residents. Although improvements were noted since the last inspection, it was not yet evident that the least restrictive practices were being used for the shortest duration.

Staff had completed additional training such as managing challenging behaviour and an introduction to positive behaviour support training. More training was planned in 2022 on autism, positive psychology, well-being, and their role in positive behaviour support. In addition, there had been a review of a number of residents' positive behaviour support plans to ensure they contained proactive and reactive strategies and were clearly guiding staff to support residents. From speaking with staff and reviewing incidents in the centre, it was evident that there had been a reduction in the number of incidents for some residents as a result of staff training, the review of support plans and the consistent implementation of measures in these support plans. However, in the provider's own audits and reviews, they recognised that staff required additional training and support to recognise restrictions and the impact of these restrictions, to recognise the function of some residents' behaviour, and to escalate any concerns they may have to ensure support plans were developed and reviewed as required.

An individual needs and preference assessment was planned for each resident in the designated centre in 2022, as the provider had recognised that some residents' assessments were not reflective of their care and support needs. As part of these assessments, the provider planned to review the compatibility of residents living together and identify residents' wishes and preferences in relation to accommodation. Inspectors reviewed a number of documents which were not reflective of residents' current care and support needs, and there was an absence of assessments and care plans for some support needs.

There was a risk management policy that contained the required information. Overall, inspectors found improvements in the oversight of risk in the centre. The provider was in the process of reviewing the risk register and general and individual risk assessments at the time of the inspection. There was now a central risk register, and this was found to be reflective of some of the main risks in the centre. The risk register and risk assessments for one of the houses were in the final stages of

development, and then plans were in place to complete a review in the other two houses. The provider had also reviewed the fire safety measures in the centre and strengthened the fire evacuation procedures in the centre in the event of a fire.

Overall, the inspectors found that residents were protected by the policies, procedures and practices relating to safeguarding in the centre. Staff had completed bespoke training with a social worker since the last inspection, and more training was planned to ensure they were aware of their role and responsibilities in recognising and reporting suspicions or allegations of abuse. Training was also being provided to staff on how to complete the relevant documentation.

There was an advocacy group on the campus where the designated centre was situated, and resident representatives from the houses sat on this group. There was information available for residents on how to access independent advocacy services, and one resident was being supported to access an independent advocate. While improvements were evident in relation to residents' choices, it was not evident that residents were being fully supported to exercise choice and control over their daily lives. The provider was aware of this and was working with staff to recognise residents' needs and to support them to make choices in relation to their day-to-day lives. They were also working to reduce restrictive practices in the centre.

Regulation 18: Food and nutrition

The provider had reviewed the mealtime experience for residents and commenced a range of observational audits to inform best practice approaches to ensure that each resident receives nutrition appropriate to their needs and choosing, taking into account each resident's wishes and preferences. These audits included observations of the human rights officer and health promotion and improvement coordinator. A number of recommendations were made from these audits, demonstrating that these audits were more effective than previously used tools. Multi-disciplinary intervention had also been sought to support the staff team with specific dietary requirements where required. Follow up spot checks by the person in charge and the clinical nurse manager 3 showed some deviation from the recommendations with actions taken to address same.

Judgment: Compliant

Regulation 26: Risk management procedures

Improvements were noted in the oversight of risk in the centre since the last inspection. A new risk register has been developed and work was ongoing on this to ensure it was reflective of the actual risks in the centre. However, more work was planned to ensure there was a risk register for each of the houses, and that general

and individual risk assessments were developed and reviewed as required. For some residents this process could not progress further until their assessment of need was completed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had reviewed the overall fire safety plan for the centre, as the night-time arrangements of evacuating residents from one of the bungalows relied on staff from other areas on campus. The fire evacuation procedure had been reviewed, updated and tested since the previous inspection. The person in charge had undertaken an unannounced night-time drill which took eight minutes to evacuate all residents. The person in charge identified the response time to the fire drill from other areas was very slow and had addressed this with staff from the other bungalows to ensure the different staff teams knew the procedures. As a result, a further night drill was completed, and the evacuation was finished in less than three minutes with no issues noted.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider recognised that there was a need to identify the needs and preferences of each resident to ensure the environment in which they live is appropriate to their needs. A comprehensive 'Individual needs and preference assessment' (IPNA) was expected to be completed by the end of the year, but the provider had delayed the deadline due to the amount of work required to complete these assessments. The inspectors observed that some residents' varying needs and compatibility did not allow for the meeting of each individual needs.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Improvements were noted in relation to the oversight of restrictive practices in the centre. The provider was in the process of implementing a new restrictive practice policy and new systems for the review of restrictive practices in the centre. However, high levels of restrictions remained in the designated centre and the provider was in the process of developing and implementing a number of restrictive

practice reduction plans to ensure the least restrictive practices were being used for the shortest duration.

There had been a review of a number of residents behaviour support needs and support plans were reviewed or developed to ensure that they were reflective of residents' support needs and clearly guiding staff practice. Further review and improvements were planned in this area.

Judgment: Substantially compliant

Regulation 8: Protection

Residents were protected by the policies, procedures and practices relating to safeguarding. Allegations and suspicions of abuse were reported and followed up on in line with the organisation's and national policy. Safeguarding policies were developed and reviewed as required.

Residents had intimate care plans in place which outlined their support needs and preferences and were sufficiently detailed to guide staff to support them.

Judgment: Compliant

Regulation 9: Residents' rights

The provider recognised that there was a risk that individuals' human rights may be compromised due to some of the restrictive practices in place in the designated centre and had developed a risk assessment. They were in the process of implementing many additional controls, such as a new restrictive practice policy and a restrictive practice review process.

A number of easy-to-read documents were in place to support residents around restrictive practices, and a number of residents had guidelines for promoting their independence and maintaining their privacy and dignity. In addition, the provider had employed a human rights officer who had visited the centre, and they were in the process of setting up a human rights committee. A number of staff had completed online human rights training, and more were planning to complete it. Residents had access to information on how to access advocacy services, and a referral had been made to an independent advocate for one resident.

While inspectors found evidence of improvements in areas such as meal-time choices, the provider was completing audits and observations in the centre and finding that there were some institutionalised practices and a need for culture change across the designated centre. They had provided staff with support from multi-disciplinary team members to recognise and understand the need for these

changes, and additional work was planned in this area.
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 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Glen 3 OSV-0003727

Inspection ID: MON-0034563

Date of inspection: 15/12/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Service Manager is working with the HR department to fill vacant posts, interviews are scheduled for 09/02/22 & 11/02/22. The PIC will review the roster template to ensure it is clear and legible. The PIC has established a system to monitor and review working rosters on an ongoing basis to ensure they are accurate.	
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 continue to up date training records and will liaise with the training department to plan and schedule training as required. All staff currently requiring refresher training will be scheduled to attend training in the first quarter	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and	

management:
The service manager has scheduled the 6 monthly provider nominee audits for 2022.

The PIC, PPIM and Service Manger will meet every quarter to monitor action plans and ensure actions are executed within agreed timeframes.

Daily morning meeting commenced 04/01/22 with PIC, PPIM and Service Manager.

The governance and oversight team continue to oversee the implementation of the plan to address areas of non-compliance and ensure delivery of quality person-centered supports to residents.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
In line with on-going review of each residents care plan a risk assessment to include management plan will be complete for all identified risk. The risk register will be updated accordingly

The Service Manager, PIC, PPIM and CNM1's are scheduled to attend Risk Management training in February 2022.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Residents care plans will be reviewed to ensure each persons health, personal and social care needs are identified with appropriate support plans in place.

The PIC has reviewed and developed a prioritized schedule to ensure an Individual Preference & Need Assessment is complete for all residents.

Referrals be made as appropriate to Admissions Discharge Team where an identified need or preference can not be met within the residents current living environment

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The Registered Provider will ensure all Restrictive Practices are reviewed in line with local and National policy.
The PIC will ensure restrictive practice reduction plans continue to be monitored and reviewed by the MDT.

The Clinical Nurse Specialist in Positive Behavior Support will be allocated to the designated center one day per fortnight commencing February 2022. The PIC will ensure Behavior of Concern risk assessments are reviewed with appropriate supports in place for residents.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The PIC will ensure all staff complete human rights training on HESLand.

Two staff will be allocated to attend specific "It's my Life Training" which will empower them to support the team in relation to person centered planning. Person centered planning training will be provided to all staff.

The Registered Provider will ensure all Restrictive Practices are reviewed in line with local and National policy.

The PIC will ensure restrictive practice reduction plans continue to be monitored and reviewed by the MDT with ongoing focus promoting a restriction free environment.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	07/02/2022
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	31/03/2022
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	Substantially Compliant	Yellow	04/01/2022

	to residents' needs, consistent and effectively monitored.			
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	30/04/2022
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 need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	30/04/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/04/2022

Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	31/03/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	31/03/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/06/2022