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:	Tignish House
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	04 July 2023
Centre ID:	OSV-0004262
Fieldwork ID:	MON-0040629

About the designated centre

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

Tignish House is a designated centre is located near a town in County Wicklow and is operated by Nua Healthcare. It provides a community residential service to four adults with an intellectual disability and autism. The designated centre is a detached two story building which consists of a kitchen come dining room, sitting room, a sensory room, a relaxation/TV room, a number of shared bathrooms, four individual bedrooms, a staff sleep over room and an office. The centre is staffed by a person in charge, social care workers and assistant support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Tuesday 4 July 2023	10:00hrs to 16:30hrs	Maureen Burns Rees	Lead
Tuesday 4 July 2023	10:00hrs to 16:30hrs	Marie Byrne	Support

What residents told us and what inspectors observed

This unannounced inspection was completed following receipt of solicited and unsolicited information by the Office of the Chief Inspector of Social Services. The information submitted raised concerns regarding the quality and safety of care in the centre. The person in charge was on leave on the day of inspection so this inspection was facilitated by the director of operations.

From what the inspectors observed, it was evident that the residents living in the centre had a good quality of life in which their independence was promoted. However, there had been a significant turnover of staff in the centre in the preceding period, there were a number of staff vacancies and the number, qualifications, and skill mix of staff was not always appropriate to meet the number and needs of residents in the centre. Although efforts were made to cover these vacancies with relief staff, there was a potential negative impact for residents in terms of consistency of care from their care givers. The provider had identified this and a number of other areas, were improvements were required. A governance driven improvement plan and number of action plans had been put in place to address the issues identified with clear time frames for actions to bring about the required improvements.

The inspectors met briefly with each of the four residents living in the centre. The inspectors observed warm interactions between the residents and staff caring for them. Over the course of the inspection, residents were observed coming and going to various activities and appointments. One of the residents met with was reluctant to engage with the inspector but appeared in good spirits and staff were observed to respond to their non-verbal cues in a kind and respectful manner. The other residents spoke briefly with the inspector and indicated that they were happy living in the centre.

The centre was registered to accommodate up to four adult residents and there were no vacancies at the time of inspection. The residents had been living together for an extended period. It was considered that overall the residents were compatible with each other and enjoyed engaging in group activities in addition to their individual interests. However, as discussed later in the report, the behaviours of a small number of the residents, on occasions could be difficult for staff to manage in a group living environment. This had the potential to have a negative impact on individual residents but overall incidents were considered to be well managed.

The centre was found to be comfortable, homely and overall in a good state of repair. However, there were areas of worn paint on some walls and wood work, there was a stain on the ceiling in the sitting room, carpet in the staff sleepover room upstairs was worn, the surface of the kitchen table was worn and the wall tile grouting in the downstairs shower room and utility room was worn and stained. This meant that these areas could be more difficult to effectively clean from an infection control perspective. In addition, there was an outside room which was primarily

used for storage but was also accessed by residents. However, this area appeared unclean. There were broken storage shelves and there was visible dust on numerous surfaces in the room. The cleaning schedule for the area were not being consistently completed. It was found that personal protective equipment for infection prevention and control, and pots used on a regular basis in the kitchen for cooking, were being inappropriately stored in this area. On the day of inspection, it was noted that there were no paper hand towels in each of the five hand washing areas in the centre. The latter was address on the day of inspection by staff. The provider had an operations and maintenance team who were responsible for the maintenance of the premises. A maintenance log was maintained of all requests and tasks undertaken.

The centre layout was suitable to meet the needs of the residents.There were a number of good sized communal areas, including a kitchen come dining room, sitting room and a sensory room. Each of the residents had their own bedroom which had been personalised to their own taste. This promoted residents' independence and dignity and, recognised their individuality and personal preferences. There were pictures of residents and their respective family members and other memorabilia on display. The centre was located in a rural setting. There was a good sized garden surrounding the centre for residents use. This included a table and chairs for out door dining, a polytunnel for planting, a set of goal posts, a swing and raised flower beds.

There was evidence that residents and their representatives were consulted and communicated with, about decisions regarding their care and the running of their home. Each of the residents had regular one-to-one meetings with their assigned key workers and there were weekly resident meetings. Residents were enabled and assisted to communicate their needs, preferences and choices at these meeting in relation to activities, daily routines, money and meal choices. There were minimal restrictions on visiting in the centre. Posters displaying individualised rights for each of the residents were on display. Residents had access to independent advocates if required.

Residents were actively supported and encouraged to maintain connections with their friends and families through a variety of communication resources and facilitation of visits. A number of the residents were facilitated to go for regular overnight stays to their family homes. The inspector did not have an opportunity to meet with the relatives or representatives of any of the residents but it was reported that they were happy with the care and support that the residents were receiving. The provider had completed a survey with residents and their representatives as part of its annual review of the quality and safety of care. These indicated that overall they were happy with the care being provided in the centre.

There was an atmosphere of friendliness in the centre. Staff were observed to interact with residents in a warm, caring and respectful manner. For example, staff were observed to knock and seek permission before entering a resident's bed room. The residents met with appeared to be in good form. Residents were observed to access various areas in the centre and the garden. The inspector noted that

residents' needs and preferences were well known to staff met with on the day of inspection and the director of operations.

Residents were supported to engage in meaningful activities in the centre. Three of the four residents were engaged with a formal day service programme on identified days each week. The fourth resident had an individualised service provided for them from the centre which it was felt best met this resident's individual needs. Examples of other activities that residents engaged in included, gym sessions, gardening, social club, arts and crafts, swimming, listening to music, cinema, bowling, walks to local scenic areas and beaches, board games, concerts and meals out. One of the residents was a keen gardener and had their own polytunnel in the garden which they used to grow a variety of plants and vegetables. A weekly activity schedule was in place. One of the residents had purchased a hot tub the previous year which they had enjoyed using. However, it had been placed in storage in the preceding period, pending the development of a more suitable area in the garden for its use. Plans were in place for the development of same and the re-commissioning of the hot tub. There were two cars available in the centre for residents' use.

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

Capacity and capability

There were appropriate management systems and processes in place to promote the service provided to be safe, consistent and appropriate to residents' needs. However, there were staff vacancies and there had been some turnover of staff in the preceding period. The provider had identified a trend of allegations of abuse and staff misconduct and implemented a governance driven improvement plan in the weeks preceding this unannounced inspection. The provider had implemented a number of control measures to mitigate the risks. These measures had brought about a number of improvements, particularly relating to staff's awareness of their personal and professional responsibilities for the quality and safety of the services they were delivering.

The provider was also in the process of implementing a number of actions to bring about improvements in relation to oversight and monitoring in the centre, including staff training and supervision. For example, some additional site specific training had been completed for staff and more was planned. Members of the providers safeguarding and human resource teams had visited the centre and floor supervision and mentoring was being completed with members of the staff team. There was also evidence of increased management presence in the centre since the governance driven improvement plan had been implemented. For example, a member of the local management or senior management team was on site daily.

The centre was managed by a suitably qualified and experienced person. They had taken up the position in November 2022. The person in charge was on planned leave on the day of inspection and the inspection was facilitated by the director of operations. The person in charge held a degree in applied social care. They had more than six years management experience. They were in a full-time position and was responsible for one other centre located within the same geographical area. However, as part of the provider's improvement plan it was proposed that in the coming weeks, the person in charge's role would be revised so they would only be responsible for this centre. The person in charge was supported by a deputy manager. Staff members spoken with, told the inspector that the person in charge supported them in their role and was a good leader. The person in charge had regular formal and informal contact with their manager.

There was a clearly defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was supported by a deputy manager and a team leader. The person in charge reported to the director of operations who in turn reported to the chief operating officer. There was evidence that the director of operations visited the centre at regular intervals and completed audits on these visits.

An annual review of the quality and safety of care and six-monthly unannounced visits as required by the regulations had been undertaken. There was evidence that the person in charge had undertaken a number of other audits and checks in the centre on a regular basis. Examples of these included, medicines practices, integrated care folders, fire safety, health and safety, weekly and monthly management checks, infection prevention and control and staff files. There was evidence that actions were taken to address issues identified in these audits and checks. There were monthly staff meetings and separately management meetings with evidence of communication of shared learning at these meetings.

There was 1.9 whole time equivalent (WTE) staff vacancies at the time of inspection. Recruitment was underway for these positions. These vacancies were being covered by relief staff but from a review of rosters, it was not evident that there were always regular or consistent relief staff used. For example, in May and June 2023, 46 shifts were covered by 14 different staff, including relief staff and four managers from different designated centres operated by the provider. The actual and planned duty rosters were found to not be consistently maintained to a satisfactory level. Of the 46 shifts covered, seven shifts did not contain the name of the staff member who had covered the shift. The number of staff employed in the centre did not reflect those stated in the statement of purpose, dated June 2023. For example, the whole time equivalent (WTE) assistant support workers on the statement of purpose was 9.8, and there were 7.5 WTE at the time of the inspection. The inspectors acknowledge that there 0.4 WTE additional social care workers in the centre at the time of the inspection, leaving 1.9 WTE staff vacancies.

There had been some staff turnover in the preceding period and five new staff had started working in the centre over a six week period. Two of these were managers, and formed part of the provider's governance improvement plan for the centre.

Based on a review of a sample of rosters for May and June 2023, it was evident that the number, qualifications, competency and skill mix of staff was not always appropriate to meet the number and assessed needs of residents in the centre. It was noted that as part of the provider's governance driven improvement plan, a review of the skills and competencies of staff in the centre was underway.

Inspectors reviewed a sample of staff files and found that they contained the required information. As the person in charge was on leave at the time of the inspection, staff supervision records were unavailable. However, inspectors reviewed supervision schedules in the centre. In addition, there was an open action on the governance driven improvement plan in the centre to ensure that staff supervision, probations and appraisals were up-to-date.

Training had been provided to staff to support them in their role and to improve outcomes for the residents. Examples of training completed included, managing behaviours of concern, safeguarding, the safe administration of medicines, manual handling, first aid, infection prevention and control, intimate care, risk assessment and autism. Staff had attended all mandatory training. There was a staff training and development policy. A training programme was in place and coordinated by the provider's training department. There were no volunteers working in the centre at the time of inspection. The management team were in the process of reviewing staff training and staff competencies to ensure they had the skills and competencies to support residents. The provider required more time to implement these actions.

Team meetings were occurring regularly and agenda items included areas such as, incidents, accidents, health and safety, audits, policies and procedures, management support, risk management, safety audit analysis, trending, fire safety, residents' goals, and residents' plans.

Inspectors found archived residents' confidential information in an external unlocked area of the centre. This was rectified by the provider during the inspection. Overall, discrepancies and inaccuracies were found across a number of documents in the centre. For example two incident reports did not reflect the information submitted to the office of the Chief Inspector in quarterly notifications regarding non-serious injuries and a resident's restrictive practice reduction plan did not reflect the content of a recent restrictive practice review meeting. There were also inaccuracies in a number of incident reports reviewed in relation to the type of incident, the actions taken, and the follow ups. For example, two incident reports that corresponded to notifications submitted to the Office of the Chief Inspector as an allegation or suspicion of abuse indicated that they were not allegations or suspicion of abuse. In addition, for one incident where restrictive practices were implemented, the incident report stated that no restrictive methods were used. As part of the provider's governance driven improvement plan, an action was in place, to review records in the centre to ensure accuracy.

Regulation 15: Staffing

There were 1.9 whole-time equivalent (WTE) staff vacancies at the time of inspection. There had been some turnover of staff in the preceding period. The actual and planned duty rosters were found not to be consistently maintained to a satisfactory level, for example a number of shifts did not contain the name of the relief staff member who covered the shift. From a review od rosters it was not evident that the number, qualifications, competency and skill mx of staff was appropriate, at times, to meet the number and assessed needs of residents in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training had been provided to staff to support them in their role and to improve outcomes for residents. Staff had attended mandatory training. There were staff supervision arrangements in place.

Judgment: Compliant

Regulation 21: Records

Inspectors found archived residents' confidential information in an external unlocked area of the centre. Overall, discrepancies and inaccuracies were found across a number of documents in the centre. For example, incident report forms and notifications to the office of the Chief inspector office, a restrictive practice reduction plan did not reflect a restrictive practice review meeting minutes. There were also inaccuracies in a number of incident reports reviewed in relation to the type of incident, the actions taken, and the follow ups. As part of the provider's governance driven improvement plan, an action was in place, to review records in the centre to ensure accuracy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The governance and management systems in place promoted the delivery of a high quality and safe service. It was noted that prior to this unannounced inspection that the provider had identified the majority of the issues and non compliances identified by the inspectors. The provider had put in place a governance driven improvement plan to address the issues identified. An annual review to review the assess the

quality and safety of care had been completed. The provider had completed unannounced visits on a six-monthly basis to review the quality and safety of care. There were clear management structures and lines of accountability. A governance driven improvement plan and number of action plans had been put in place to address the issues identified with clear time frames for actions to bring about the required improvements.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained and overall where required, these were notified to the Chief Inspector, within the timelines required in the regulations. It was noted that there had been one incident which had not been submitted on a quarterly notification.

Judgment: Compliant

Quality and safety

The residents living in the centre received care and support which was of a good quality, person centred and promoted their rights. However, the behaviours of a small number of residents were on occasions difficult for staff to manage in a group living environment and had the potential to have a negative impact on other residents. Overall, incidents of behaviours of concern were considered to be well managed.

The residents' well being and welfare was maintained by a good standard of evidence-based care and support. Three of the four residents attended a formal day service programme. The fourth resident had a personalised programme provided for them in the centre which it was felt better met that residents needs. Personalised care and support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their personal development in accordance with their individual health, personal and social needs and choices. Personal plans in place had been reviewed with the involvement of the individual resident's multidisciplinary team, the resident and their representatives. The effectiveness of the plans were assessed as part of a review as required by the regulations. Health action plans were place for residents identified to require same. Specific goals were identified for residents. Records were maintained of session planning to achieve goals and one to one meetings to record progress in achieving identified goals.

The health and safety of the residents, visitors and staff were promoted and protected. There was a risk management policy and environmental and individual risk assessments for residents which had recently been reviewed. These outlined appropriate measures in place to control and manage the risks identified. Health and safety audits were undertaken on a regular basis with appropriate actions taken to address issues identified. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents. Post incident reviews were completed. This promoted opportunities for learning to improve services and prevent incidences.

Suitable precautions were in place against the risk of fire. There was documentary evidence that fire fighting equipment and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. There were adequate means of escape and a fire assembly point was identified in an area to the front of the centre. A procedure for the safe evacuation of residents in the event of fire was prominently displayed. Each of the residents had a personal emergency evacuation plan which adequately accounted for the mobility and cognitive understanding of the individual resident. Staff who spoke with the inspectors were familiar with the fire evacuation procedures and had received appropriate training. Fire drills involving each of the residents were undertaken at regular intervals.

There were procedures in place for the prevention and control of infection. However, there were areas of worn paint on some walls and wood work, there was a stain on the ceiling in the sitting room, carpet in the staff sleep over room upstairs was worn, the surface of the kitchen table was worn and the wall tile grouting in the downstairs shower room and utility room was worn and stained. This meant that these areas could be more difficult to effectively clean from an infection control perspective. In addition, there was an outside room which was primarily used for storage but was also accessed by residents. However, the area appeared unclean. There were broken storage shelves and there was visible dust on surfaces in the room. The cleaning schedule for the area were not being consistently completed. it was found that personal protective equipment for infection control and pots used on a regular basis in the kitchen for cooking, were being inappropriately stored in this area. On the day of inspection, it was noted that there were no paper hand towels in each of the five hand washing areas in the centre. This was address on the day of inspection by staff. A cleaning schedule was in place which was overseen by the person in charge and deputy manager. Cleaning was completed by staff on duty. Colour-coded cleaning equipment was in place. There were adequate arrangements in place for the disposal of waste. It was noted that a clinical waste bin in situ was not being used and measures were taken to have this removed on the day of inspection. Specific training in relation to infection control, proper use of personal protective equipment and effective hand hygiene had been provided for staff. Individual work had been completed with a number of the residents regarding infection control.

There were measures in place to protect residents from being harmed or suffering from abuse. However, the behaviours of a number of the residents were on occasions difficult for staff to manage in a group living environment. This had the

potential to be a safeguarding concern and to have a negative impact on the other residents in the centre but generally incidents were well managed. It was noted that allegations or suspicions of abuse had been appropriately reported and responded to. The provider had a safeguarding policy in place. Individual work had been completed with some of the residents regarding how to keep themselves safe. Staff members spoken with, were knowledgeable about the signs of abuse and what they would do in the event of an allegation, suspicion or disclosure of abuse. Staff had attended appropriate training. Intimate care plans were on file for each of the residents and these provided sufficient detail to guide staff in meeting the intimate care needs of the individual residents.

Residents were provided with appropriate emotional and behavioural support and their assessed needs were appropriately responded to. A register was maintained of all restrictive practices used in the centre and these were subject to regular review. There was evidence that alternative measures were considered before using a restrictive practice and that the least restrictive practice was used for the shortest duration. Behaviour support were in place for residents identified to require same. These had been reviewed by the provider's behaviour consultant. The plans put in place provided a good level of detail to guide staff in meeting the needs of the individual resident. There was a policy on the provision of behaviour support and staff had received appropriate training.

Regulation 17: Premises

The centre was found to be homely, suitably decorated and overall in a good state of repair. However, there were some worn and broken surfaces which had implications from an infection control perspective as referred to under Regulation 27.

Judgment: Compliant

Regulation 26: Risk management procedures

The health and safety of the residents, visitors and staff were promoted and protected. Environmental and individual risk assessments and safety assessments were on file which had been recently reviewed. There was a risk register in place. There were arrangements in place for investigating and learning from incidents and adverse events involving the residents.

Judgment: Compliant

Regulation 27: Protection against infection

There were areas of worn paint on some walls and wood work, there was a stain on the ceiling in the sitting room, the carpet in staff sleep over room upstairs was worn, the surface of the kitchen table was worn and the wall tile grouting in the downstairs shower room and utility room was worn and stained. This meant that these areas could be more difficult to effectively clean from an infection control perspective. In addition, an adjacent room outside appeared unclean. There were broken storage shelves and there was visible dust on surfaces in the room. The cleaning schedule for the area were not being consistently completed. it was found that personal protective equipment for infection control and pots used on a regular basis in the kitchen for cooking, were being inappropriately stored in this area. On the day of inspection, it was noted that there were no paper hand towels in each of the five hand washing areas in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

Suitable precautions were in place against the risk of fire. There was documentary evidence that fire fighting equipment and the fire alarm system were serviced at regular intervals by an external company and checked regularly as part of internal checks in the centre. There were adequate means of escape and a fire assembly point was identified in an area to the front of the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident's well being and welfare was maintained by a good standard of evidence-based care and support. Personal support plans reflected the assessed needs of the individual residents and outlined the support required to maximise their quality of life in accordance with their individual health, personal and social care needs and choices.

Judgment: Compliant

Regulation 6: Health care

Each resident's healthcare needs appeared to be met by the care provided in the centre. Each of the residents had their own general practitioner (GP) who they visited as required. A healthy diet and lifestyle was being promoted for the residents. A hospital passport sheet was in place with pertinent information should a resident require unexpected transfer to hospital.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents appeared to be provided with appropriate emotional and behavioural support. Behaviour support and routine management plans were in place for residents identified to require same. It was noted that a number of residents presented on occasions with behaviours of concern. However, it was considered that incidents were overall being managed well by the staff team. There was a restrictive practices register in place which was subject to regular review.

Judgment: Compliant

Regulation 8: Protection

There were measures in place to protect residents from being harmed or suffering from abuse. However, as referred to above, the behaviours of a number of residents were sometimes difficult for staff to manage in a group living environment and this had the potential to be a safeguarding concern and to have a negative impact on the other residents in the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The residents' rights were promoted by the care and support provided in the centre. There was evidence of active consultations with each resident and their families regarding their care and the running of the centre. Individual work had been completed with individual residents regarding their rights. Posters displaying residents rights were on display. Residents were observed to be treated with dignity and respect.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Tignish House OSV-0004262

Inspection ID: MON-0040629

Date of inspection: 04/07/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Person in Charge (PIC) shall complete a review of 'actual' and 'planned' rosters in the center, to ensure staffing levels are correct and in line with individuals assessed needs. Note: This was completed on 19 July 2023. The PIC will continue to review staffing levels daily and in conjunction with the recruitment team, the PIC and Director of Operations (DOO) will review the Centre's recruitment plan on an ongoing basis. 2. The Centre's Staffing Contingency Plan will be reviewed and updated by the PIC to clearly outline the Staffing Arrangements in place to meet the assessed needs of individuals as well as what measures are implemented to maintain continuity of care. 3. The Statement of Purpose shall be reviewed and updated by the PIC as and where required to ensure staffing levels are aligned with the Centre's existing staffing levels and individual occupancy level. Note: This was completed on 19th July 2023.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. The Person in Charge (PIC) will ensure that there are systems in place to ensure archived information is securely stored behind a locked door in line with Centre's Policy and Procedure on Archiving [PL-HR-009].	

2. The PIC in conjunction with the Behavioral Specialist will complete a further review of all Restrictive practices within the Centre and ensure minutes are completed, are accurate and are in line with the current restrictions within the Centre.

3. The PIC in conjunction with the Behavioral Specialist will review all incidents reports which have occurred in the Centre in 2023 to ensure all incidents are accurately recorded with clear learnings with identified for the staff team.

4. The PIC shall discuss the above points at the monthly Staff Team Meeting to be held by 31st August 2023.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
1. The Director of Operations (DOO) shall complete a review with the maintenance department and confirm a schedule to be set for completion of required works identified following the review and from the inspection.

Note: This was completed on 06 July 2023 as part of the Centre's Governance Driven Improvement Plan.

2. The Person in Charge (PIC) shall conduct a review of the Infection, Prevention and Control (IPC) systems in place to ensure the environment is checked daily, and any maintenance or repairs are scheduled and addressed in a timely manner and PPE equipment is appropriately stored, and appropriate cleaning systems are in place.

Note: This was completed on 06 July 2023 as part of the Centre's Governance Driven Improvement Plan and as part of the review, the unused storage shelf was removed.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
5. The Person in Charge (PIC) and The Director of Operations (DOO) will complete a full review of all Individuals Impact Assessments to ensure all residents are suitable and capable of living with another, and any associated controls are identified and implemented to manage any potential risks.

6. To ensure all safeguarding concerns are reviewed and the effectiveness of safeguarding plans in place, The Designated Safeguarding Officer will implement a Centre Specific Safeguarding Plan and will conduct Safeguarding Review meetings with a schedule in place for, (1) one Safeguarding review meeting in Quarter 3 and (1) one Safeguarding review meeting in Quarter 4.

7. The Designated Safeguarding Officer will complete an additional Centre visit to meet with all Individuals and follow up with actions from previous Centre visits.

8. The PIC shall discuss the above points at the monthly Staff Team Meeting to be held by 31st August 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	19/07/2023
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	19/07/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	19/07/2023

	showing staff on duty during the day and night and that it is properly maintained.			
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	31/08/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	06/07/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/08/2023