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:	No 2 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	07 May 2024
Centre ID:	OSV-0004572
Fieldwork ID:	MON-0034335

About the designated centre

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

No. 2 Seaholly comprises two detached bungalows, located on a campus with a number of other designated centres operated by the same provider, on the outskirts of Cork city. The designated centre is registered to accommodate nine adults at any one time. Five residents live in one house, and four in the other. Each bungalow has its own garden area. A full-time residential service is provided to five residents in one house. In the other house, two residents live there on a full-time basis, while two others regularly stay on a respite basis. This house has a self-contained apartment, used by one resident. Each resident of No. 2 Seaholly has been diagnosed as functioning within the range associated with a moderate to severe level of intellectual disability. Some residents also have an autism diagnosis. The centre is staffed at all times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 7 May 2024	09:00hrs to 17:00hrs	Laura O'Sullivan	Lead
Tuesday 7 May 2024	09:00hrs to 17:00hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

At the time of this inspection, this designated centre was comprised of two detached houses located on a campus setting. A separate office space for the person in charge was located between both houses although this was not part of the designated centre's footprint. On the day of the inspection four residents were present in the centre with three residents in one bungalow and one resident in the other. While inspectors spent some time in the person in charge's office reviewing certain documentation, both houses were visited by one inspector each. During these visits inspectors met three residents and also had opportunities to observe residents in their environments and in their interactions with staff members on duty.

When an inspector initially visited one of the houses, the one resident living there was in bed. As such the inspector did a walk-around of the premises. Five residents had previously lived in this house but four of these had transitioned to a community based designated centre operated by the same provider in December 2023. As a result there were four vacant bedrooms in the house along with communal areas including a relaxation room, a dining-living room and a kitchen. Such rooms were observed to be nicely maintained, clean and homely.

This house was also provided with a staff office where documents were kept along with a press to store the resident's money. Although this press was lockable, it was seen throughout the inspector's time in this bungalow that this press was left unlocked which did not promote security of the resident's money. In addition, within the staff office there were two fire panels, a smaller one and a larger one. The inspector was informed that the smaller fire panel was for the house itself while the larger fire panel covered all other designated centres on the campus. When asked by the inspector why this larger panel was located in this house, those spoken with were unsure as to why this was the case. The inspector was informed though that because of the presence of this fire panel, if the fire alarm in another designated centre was triggered, the fire alarm in the bungalow would also be activated. It was noted that there was a protocol for staff on how to respond should this scenario occur.

The resident in this one house, did not directly interact with the inspector at this time but did appear relatively calm. Not long after this introduction, the resident was supported to leave the house to go for a walk on the campus with one staff member while another staff member was overheard making telephone calls seeking to arrange transport for the resident for an upcoming appointment later in the week. The statement of purpose for the centre indicated that that the centre had access to transport with arrangements for this to be organised. When asked staff told the inspector that the house did not have a transport vehicle specifically assigned to it but the resident would have access to a day services vehicle at weekends and for evenings during weekdays. If transport was needed outside of these times, a vehicle would need be sourced from another centre or day service. It was later confirmed by a member of management that a transport vehicle had been previously assigned

to this house but when the four residents who used to live in this bungalow transitioned elsewhere, the vehicle had moved with them.

The resident returned to the house in the early afternoon and spent some time in the dining-living room listening to music. It was indicated that this was something that the resident did but incidents records reviewed highlighted that at times the resident could engage in a particular of behaviour while in this room. A staff member spoken with suggested that the resident did this to signify that they "were bored" and that staff were to engage with the resident during such times. While the resident was in the dining-living room on the day of inspection, it was observed and overheard that a staff member used some picture cards to offer the resident a choice to go have a meal in a day service located on the campus. The resident did not appear to respond to these cards so the resident was facilitated to have their meal in the bungalow with the support of a staff member.

All residents' bedrooms was seen by the inspectors over the course of the inspection and were observed to be personalised to the interests of the resident. Interactions observed were seem to be courteous and respectful. Staff spoken with were aware of the needs of the residents and overall were observed to support them in a positive manner.

The inspector spent time in the other house under the remit of the centre. One resident who was afforded supports through shared care was attending a day service of their choice. This resident was supported in a private living area. Staff spoke of resident doing well and promoting their skills in such areas as food preparation. This was reflected within the personal plan. A second "bedroom" within this private area was currently in use as a second living area. The provider did speak of this room being used a bedroom if required however no plan was in place should this be required. No storage was available within the room and the size of the room was noticeably small. This required review.

Within the main area of the house three residents were supported. Two in a full time capacity and one on a shared care basis. As will be discussed later in the report a review was required to ascertain if the support provided was shared care or respite. One resident was in bed on the morning of the inspection. Staff spoke of this resident requiring additional support to commence their day. Upon awakening the resident said hello to the inspector but chose not to interact further but go about their day. They enjoyed helping staff with their chores. The staff did speak that at times did resident could engage in aggressive behaviour. A staff member was observed supporting the resident outside of the house walking in front of them in an unsafe manner. This required review.

The next two sections of the report will review the capacity and capability, and the quality and safety of the service provided and the impact of this on the residents.

Capacity and capability

In March 2024, the provider submitted an application to renew the registration of this centre for a further three years beyond September 2024 but with only bungalow remaining within the footprint of the centre. The provider also applied to register the remaining bungalow as a standalone designated centre in March 2024 as part of a reconfiguration. As both houses remained registered as part of No.2 Seaholly, the current inspection was conducted with a view to informing both registration applications.

There was a requirement of a review of the services to be provided with in the centre. This included both within the resident's individual service agreements with the provider and the statement of purpose. One clarification was pertaining to the practice of respite or shared care within the centre and what can be afforded to residents in line with both documents.

Over the course of the inspection regulatory actions and areas for improvements were identified around residents' rights, safeguarding, notification of incidents and the use of PRN medicines (medicines only taken as the need arises). The nature of these issues raised concerns around aspects of the monitoring and oversight of the centre with the overall findings of this inspection indicating that issues were not being appropriately identified and/or addressed in a timely manner. The provider did have monitoring systems in operation which included completing key regulatory requirements such as annual reviews and six monthly unannounced visits to the centre by representatives of the provider. Written reports of such monitoring were available for inspectors to review. When reading the most recent annual review completed in June 2023, it was seen that it did assess the centre against relevant national standards and provide for family feedback. However, it did not include resident feedback as required. The two most recent provider unannounced visits had been conducted in December 2023 and April 2024.

The registered provider had appointed a skill mix to the centre. However improvements were required to promote continuity of care for all residents living in the centre. While staff vacancies were present the provider was actively recruiting. Where a staff team had been appointed there was an increased need for oversight of the training requirements to ensure this incorporated all staff providing supports including relief, agency and the core staff team.

Registration Regulation 5: Application for registration or renewal of registration

The purpose of the inspection was to monitor ongoing compliance to the Health Act 2007 and to assist in the recommendation to renew the registration of the centre for a further three cycle. The provider had submitted a full application to process the renewal of the registration. For the purpose of the registration renewal of th centre

one house currently under the remit of the centre was to be removed from the registration of the centre.This incorporated the required information such as the floor plans of the centre, evidence of insurance and a planning declaration. Amendments were required to the statement of purpose and clarity on the function of a room in the centre.

This will be addressed under Regulation 3.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had ensured the appointment of a suitably qualified and experienced person in charge of the centre. This was verified by the inspectors through a review of prescribed information submitted as part of registration renewal application including evidence of qualifications and employment history. This individual was fulltime in their role and maintained effective oversight over the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The inspectors reviewed the actual and planned rosters which were completed by the person in charge for daytime hours, these incorporated the staff members allocated to each house under the remit of the centre. The oversight of night-time rosters was not overseen by the person in charge. While staff rosters were being maintained, when reviewing these it was noted that they did not include the full names of staff working in the existing centre. This made it more difficult to clearly identify who had worked in the centre on a given day.

Within a resident's personal plan, it was highlighted the importance of familiar staff to meet their assessed needs. Within the staff roster, it was noted that familiar staff were present during daytime hours, however, the resident did not have regular staff supporting their assessed needs during night time hours. It was noted by the governance team that recruitment was ongoing to ensure continuity of care was provided for all residents.

Members of the governance team spoke to inspectors of one individual requiring support from a male member of staff. This was no evidence provided on the day of the inspection to account for this need. There was no system in place to ensure that this support need was in place consistently.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspectors reviewed a training matrix which the person in charge utilised to monitor the training needs of staff within the centre. This was not up to date on the morning of inspection as the person in charge did not oversee the training requirements of staff completing shift on nights. The matrix did also not reflect the staff members present on the roster provided including agency and relief staff.

An updated training matrix was submitted by the person in charge in the days following the inspection. However this did not include relief staff. While this indicated that most staff had completed training in relevant areas, such as safeguarding vulnerable adults form abuse, infection prevention and control and fire safety. An identified support need within the centre was in the area of behaviours of concern. Despite this a number of staff had not completed training in this area. Four staff present on the training matrix had outstanding requirements in this area.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had ensured a directory for residents was in place within the centre. The inspectors reviewed the document which evidenced that this included most of the required information, such as residents' particulars and dates of admission to the centre.

However, when reviewing the directory of residents in one bungalow it was seen that one resident's details did not include the name and address of any authority, organisation or other body who had arranged the resident's admission to the centre. The same directory did not include former residents who have lived in this bungalow until recently.

Judgment: Substantially compliant

Regulation 22: Insurance

As part of the inspection preparation, the provider had submitted evidence to ensure the designated centre had appropriate insurance.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had ensured the appointment of a clear governance structure. The person in charge reported directly to the person participating in management and is supported by an appointed area manager. There was evidence of clear communication within the governance structure.

The person in charge completed a range of onsite monitoring tools to oversee the day to day operations of the centre. This included: Review of the safety statement, Individual risk profiles and Fire safety. Through review of documentation by inspectors, it was evidenced that there was not a consistency in the completion of these tools within both houses under the remit of the designated under the remit of the centre.

From observations on the day of the inspection and review of onsite documentation a number of areas within the area of governance and management required improvement. This included;

- The most recent annual review completed did not provide for consultation with residents.
- The two most recent provider unannounced visits for centre contained varying levels of information and detail while both focused on just one of the two houses under the remit of the centre. This resulted in one bungalow not being subjected to a provider unannounced visit for some time even though a resident had been residing in that bungalow when the two most recent visits took place.
- Regulatory actions and areas for improvements were identified during this inspection around residents' rights, safeguarding and the use of PRN medicines. The nature of these issues raised concerns around aspects of the monitoring and oversight of the centre with the overall findings of this inspection indicating that such issues were not being appropriately identified and/or addressed in a timely manner.

Judgment: Not compliant

Regulation 3: Statement of purpose

A statement of purpose was in place which upon review contained some of the required information and had been reviewed recently by the person in charge. However, this required review.

- It was not clear within the document the short term supports afforded to

some individuals. It was referred to as both short term care and respite care.
- The function of one room was not clearly set out.
- The whole time equivalent of the person in charge required review.

Judgment: Not compliant

Regulation 31: Notification of incidents

Under this regulation the Chief Inspector must be informed of particular events that happen in a designated centre within a specific time period. This is important to ensure that the Chief Inspector is aware of matters which could adversely impact the quality and safety of care and support received by residents. Amongst the events that must be notified are allegations or incidents of a safeguarding nature which must be notified within three working days.

However, despite the regulatory requirements in this area, this inspection found that, while some incidents had been notified, other incidents of safeguarding nature where a resident in one bungalow had impacted others had not been notified within three working days or had not been notified at the time of this inspection.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had ensured the development of a complaints procedure to ensure all residents were supported to submit a complaint as they saw fit. This included the appointment of a complaints officer, a complaints pathway and a times approach to complaints.

The inspector reviewed the complaints folder maintained by the person in charge. Within the documentation reviewed their was evidence of adherence to the provider policy, communication with the complainant and where possible satisfaction of the complainant. Should it be required the provider had appointed a third party to investigate a complaint should a resolution not be obtained.

Judgment: Compliant

Quality and safety

This designated centre can provide full residential support for eight residents.

Accommodation provided was reflective of the residents assessed needs, this included the level of support to be provided with some improvements required to ensure compliance to the regulations. Residents' rights were promoted within the centre with residents consulted in the day to day operations of the centre, with some improvement required to ensure all areas such as nightly checks were discussed. Residents completed regular house meetings to discuss such topics as group activities and weekly menu.

Each resident in the centre was supported to develop a comprehensive individual personal plan. This included an annual review of needs from a multi-disciplinary perspective and provide guidance on holistic supports such as health and social care. Through the completion of an annual person centred meetings residents were consulted in the review of their plan and in the development of personal outcome goals such as seasonal craft work and skills promotion. Residents in the centre were provided with the opportunities to engage in meaningful activation. This included access to local day services, community activities and family connections.

Improvements were required in the area behaviour support and the measures within the centre surrounding this. This included not only the support needs of the individual but the review of impact of the behaviours on others and the review the risk post an incident.

Regulation 13: General welfare and development

All residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. On the day of inspection residents were supported to attend activities of their choice both with in the house and in the wider community.

Residents had been supported to develop personal outcome measures for the coming year with the support of staff. These included such goals as promoting skills, making seasonal crafts and the development of social stories for chosen activities. Each resident has an appointed keyworker to support them to develop and review their outcomes.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises presented as warm and homely. Residents each had a private bedroom and living spaces were tastefully decorated.

Judgment: Compliant

Regulation 20: Information for residents

A residents' guide was in place that contained all of the required information such as a summary of services and facilities, arrangements for visitors and how to access inspection reports.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had ensured systems were in place for the assessment, management and ongoing review of risks in the designated centre. Risks were managed and reviewed through a provider developed centre-specific risk register and individual risk assessments. The risk register outlined the controls in place to mitigate the risks. While the provider did have a risk management policy in place and had made changes to their emergency on-call arrangements, improvement was identified relating to this regulation in the following areas;

- A serious incident review had not been completed for a particular incident that took place in February 2024.
- While a serious incident review had been completed for an incident that had occurred in May 2024 and the provider had taken measures in response, it was highlighted that there had been a systems failure in the emergency on-call arrangements in place for campus.
- While risk assessments were in place for identified risks, it was seen that the risk ratings applied did not reflect the frequency that some incidents were occurring or did not include specific control measures that were in place. In addition, while some risks were not described in the appropriate sections of their related risk assessments.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety systems provided in both houses of the centre included a fire alarm, emergency lighting, fire extinguishers and fire containment measures. Such systems were serviced at regular intervals by external contractors to ensure that they were in proper working order. The fire evacuation procedures were seen to be on display in

the bungalows.

Fire drills conducted indicated low evacuation times. Residents had personal emergency evacuation plans provided outlining the supports they needed to evacuate if required. Overall fire evacuation plans had been recently updated to take account of how to call for assistance in the event of a fire occurring at night.

In one house, however, it was found that an outdated fire evacuation plan from 2022 for the bungalow remained in place in a prominent location. This outdated evacuation plan indicated that five residents were living in the bungalow when in reality there was only one.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Upon review of residents' personal plans it was evident that it these were regularly reviewed and contained relevant information on how to support the resident in areas such as intimate care, communication and healthcare.

The residents' personal plans had also been subject to an annual multidisciplinary review. Discussions with staff working with this resident and the contents of the resident's personal plan indicated that one resident's current low stimulus environment was suited to their assessed needs. Staff spoken with were aware of the residents' personal plan and what these incorporated.

Judgment: Compliant

Regulation 6: Health care

When reviewing records related to residents, including personal plans, medical records and support plans, it was evident that the residents through clear healthcare plans provided were supported in various health related concerns. Staff spoken with demonstrated a good understanding of these. Residents was also supported to access various health and social care professionals such as general practitioners, cardiologists, dentists and occupational therapist.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents currently residing within the centre had an assessed need in the area of behaviour support. However, improvements were required to ensure effective support was provided. As discussed previously not all staff had completed training in the area of behaviour support.

Protocols for interaction with a resident present were not dated and it was not clear when these had last been reviewed. Where a resident had increased supports in this area support from the multi-disciplinary team had been extended to every 6 months from 3 months with no rationale in place for same. Also, it was noted that where behavioural support was an assessed need this had not been discussed with the annual assessment of needs.

A resident had a plan in place in the use to prescribed medication to support them at times of concern. From review of incident forms for a two month period there was evidence of inconsistency in staff approach to this. The criteria for its administration was open to interpretation. Protocols in place for the use of PRN medications did not correlate with proactive and reactive strategies in place.

Judgment: Not compliant

Regulation 8: Protection

The person in charge reported to the inspector there was no identified safeguarding in one house under the remit of the centre. Within the second house the impact of a resident's behaviour on others was not identified. Following a serious incident one resident with support from their family had complained of the impact of this. Another resident on a number of occasions had complained of the noise and the negative impact of this.

Where an incident occurred the documentation reviewed did not account accurately who was present in the area. This did not allow for effective review of potential safeguarding concerns within the centre.

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 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for No 2 Seaholly OSV-0004572

Inspection ID: MON-0034335

Date of inspection: 07/05/2024

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	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The registered provider will ensure that residents receive continuity of care and support particularly in circumstances where staff are employed on a less than full time basis by the following

• The provider issued a protocol on the 4/6/24 providing clarity in relation to roles and responsibilities for the Person in Charge and the night supervisors who support the person in charge.

• The permanent night staff are supervised and line managed by the Person in Charge. They are included on all planned and actual rosters.

• The relief night rostering is completed by the night supervisors in conjunction with the Person in Charge.

• Regular night staff were allocated to one house in the Centre on 03.05.24 to ensure that all person supported now have consistent staffing available to meet their assessed needs. These staff members are managed by the Person in Charge.

• The Person in Charge has ensured staff rosters were amended to include the full names and job roles of the staff members 11.05.24.

• A recommendation for increased male staffing identified in February 2024 is available in the Centre. The Person in Charge amended rosters to increased male staffing hours with one person supported. An additional male staff member has been recruited and will commence 18.08.24. The PIC will continue to monitor the roster to ensure male staff is in place consistently.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person in Charge works to ensure that staff were appropriately supervised and informed of the Act and regulations. All staff are supported to receive training on various issues including on human rights and a rights-based approach to providing safe services and supports to residents. Induction and ongoing training programmes are planned and a training matrix is maintained in the Centre.

• Four staff members requiring training in behaviours of concern will have completed this by 01.07.24 on HSELand. The Person in Charge has also requested the services CPI training. This training will be completed by 30.09.2024

• All nighttime and relief staff members are now included on the training matrix 01.07.24. A log of trainings for agency staff will be maintained alongside this matrix.

• The person in charge will ensure staff have access to appropriate training including refresher training as part of a continuous development programme.

• The Person in Charge will ensure specific training requirements to meet the needs of the residents are identified and planned.

• The person in charge ensure that training and refresher training is scheduled as required

Regulation 19: Directory of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 19: Directory of residents:
• The registered provider has ensured a directory of residents is in place.

• Details of former residents, previously held on the directory and removed in error, have now been restored to the directory (31.5.24) and will be held there for a period of 7 years.

• The person in Charge will include detail in relation to the name and address of the authority who arranged the resident's admission to the Centre. 08.07.24

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider will ensure the following actions on the governance systems for oversight and management of the Centre

• Annual review of the quality & safety of care and support at the Centre scheduled for July 2024 will include consultation with the residents.31.07.24

• Provider unannounced visits conducted at least every six months, will ensure that each designated centre contacting more than one house is equitable reviewed moving forward. 31.05.2024

• All audits completed will ensure consistency in the completion of the audit tools within both houses in this designated centre. 31.05.24

• All staff are supported to receive training on human rights and a rights-based approach to providing safe services and supports to residents. The service has a rights committee and any identified concerns in relation to residents rights will be referred to this committee for independent review.

• One safeguarding concern, which had not been notified, was retrospectively sent to the chief inspector on 26.06.24.

• The Positive Behaviour Support worker reviewed proactive and reactive strategies with individual staff member's week commencing 24.06.24 to ensure a consistent approach. These will be correlated into the persons PRN protocol.

• The Provider ensures that the actions arising from internal audits and inspections by the Authority are acted upon on a timely basis.

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of

purpose:
• The registered provider updated the statement of purpose on 29.05.24.The updated SOP provides clarity on the services provided in No.2 Seaholly.

• Floor plans were revised to update the function of one room. 29.5.24

• The whole time equivalent of the Person in Charge was reviewed and updated. 29.05.24

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The person in Charge will ensure that all notifications to the Authority are complete and in particular:-

• One incident, which was identified during the inspection that had not been notified, was retrospectively sent to the chief inspector on 26.06.24.

• Quarterly returns include all occasions on which a restrictive procedure including physical, chemical or environmental restraint was used 31.07.24

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• The registered provider has ensured that risk management procedures are in place in the Centre. Each person supported has individualised risk assessments and a Centre risk register is in place.

• In relation to an incident that occurred in February 2024 the Person in Charge held a review meeting on the 7/2/24 with Multi-Disciplinary members, the staff team and the consultant Psychiatrist were in attendance to review and learn from the incident. The recommendations from that review have been implemented.

• The Provider will ensure that clear guidance is available on review of incidents including when a serious incident review will be necessary. 30.09.24

• The provider has implemented an alternative alert system following the outcome of the systems failure in the emergency alert arrangements in place for campus. 2.05.24

• Risk is reviewed quarterly by the person in Charge and more often if required.

• The Person in charge has reviewed the risk ratings for all risks identified in the Centre and amended as appropriate. 31.05.24

• All control measures will be included on the risk assessments by 08.07.24

• Risk management is a standing agenda item the local house meetings.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The person in Charge has ensured that fire precautions are in place in the designated Centre. Evacuations are occurring within agreed timelines and evacuation times are within safe timeframes.

• Staff have received appropriate training.

• An outdated Fire evacuation plan was removed on 07.05.24

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• Four staff members completed on-line Positive Behaviour Support training on 01.07.24. Crisis Prevention including de-escalating techniques in-person training is scheduled to be completed by 30.09.2024

• An Interaction protocol for one person supported is under review with the Positive Behaviour Support team, in the interim the current protocols were dated and reviewed. 31.05.24

• The intensive support worker reviewed proactive and reactive strategies with individual staff member's week commencing 24.06.24 to ensure a consistent approach. These will

be correlated into the persons PRN protocol.

• A meeting is scheduled with the intensive support worker and full staff team on 23.07.24 to agree all protocols in relation to one person supported. These will be included

• The person in charge will follow up with the multidisciplinary team to establish the rationale as to why a resident who has increased supports was extended to 6 months from 3 months. 31/8/24

• The Person in Charge completed a Multi-Disciplinary referral for one person on 14.05.24 and will work to implement the recommendations arising therefrom.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The registered provider has ensured that all staff are trained to recognize indicators of safeguarding issues and as a team to develop safeguarding plans as required to protect residents.

• Residents are supported to make complaints, which may be addressed locally in the first instance as per policy. Following the complaints received the following measures were put in place:

1. A referral to the rights committee 20/2/24, final report with recommendations issued on the 18.4.24.
2. A tracking form to establish if any further impact is observed from the person supported.23/3/24 for a 2 week period
3. A consultation with the designated officer and subsequent safeguarding referrals x two has ensured that a safeguarding plan is in place 1/4/24.

• One safeguarding concern, which had not been notified, and the time of inspection was retrospectively sent to the chief inspector on 26.06.24.

• A meeting is scheduled with the Positive Behaviour Support intensive support worker and full staff team on 23.07.24 to agree all protocols in relation to one person supported this will include discussion on documenting who was present in the property when an incident occurs and whether residents were affected.

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(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.	Not Compliant	Orange	18/08/2024
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	04/06/2024
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	Not Compliant	Orange	30/09/2024

	development programme.			
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	08/07/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	26/06/2024
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	31/07/2024
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 the safety and	Not Compliant	Orange	31/10/2024

	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	30/09/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	07/05/2024
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Not Compliant	Orange	29/05/2024
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or	Not Compliant	Orange	26/06/2024

	confirmed, of abuse of any resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2024
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	30/09/2024
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning	Not Compliant	Orange	31/08/2024

	process.			
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	23/07/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	23/07/2024