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:	The Abbey
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	06 April 2022
Centre ID:	OSV-0004761
Fieldwork ID:	MON-0033780

About the designated centre

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

The centre comprises of two separate houses. In each house an individualised service is provided for one resident over the age of 18 years. Both houses are located in residential areas of a large town and transport is provided for each resident to access their local community. Each resident has access to all of the facilities offered in a residential type setting and share their home only with the staff on duty. Residents are assessed as requiring a higher level of support from staff and there are always staff on duty. Staffing levels and arrangements differ in each house based on the assessed needs of each resident. The residents are offered an integrated model of care where both day and residential supports are provided in their home. The day to day management of the centre is delegated to the person in charge supported by a social care worker in each house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 April 2022	09:45hrs to 17:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This Inspection was undertaken to follow-up on the findings of the previous HIQA (Health Information and Quality Authority) inspection of the 4th February 2021. The registration of the centre had been renewed by HIQA with a condition attached that the provider address specific non-compliance in relation to the suitability of the premises and fire safety arrangements within a certain timeframe. The provider had submitted an application seeking an extension of that timeframe.

Based on what the inspector saw, read and discussed there was evidence of improvement. The provider had undertaken a full review of all findings arising from the last HIQA inspection. Systems were put in place to better monitor the consistency of the support and care provided to residents. However, there were still some gaps and some inconsistency found on this inspection. This demonstrated an ongoing requirement for robust management and oversight so as to better assure the appropriateness and safety of the service provided to residents.

The non-compliance identified at the time of the last inspection and the condition attached to the registration of the centre was specific to one of the two houses that comprise this designated centre. Therefore, the inspector was based in that house so as to observe for example, the arrangements in place to ensure the resident could safely use the stairs. The inspector also met with members of the senior management team to discuss the governance and management plan submitted to HIQA following the last HIQA inspection and the new plans for meeting the outstanding areas of non-compliance.

The inspector had the opportunity to meet with one resident. The assessed needs of the resident include communication differences and verbal communication is not the resident's primary means of communication. The resident did not demonstrate any great interest in the presence of the inspector in their home but equally was not perturbed in any way and continued with their planned routines.

The resident, having experienced a recent period of ill-health, presented as healthy and well. The inspector found arrangements were in place to ensure the resident enjoyed good health. For example, there was evidence of staff oversight and regular consultation and engagement with the resident's general practitioner and hospital based services.

In the context of COVID-19 the resident was re-engaging with community based services and redeveloping contact with friends and peers. The resident had regular and ongoing family contact as this was a very important aspect of their life. The resident came and went to the house with staff during the day and clearly understood any guidance or request made by staff. For example, the resident got their coat, their protective face-shield and their medication bag when getting ready to leave the house with staff. The inspector noted how the resident gestured to the kettle and staff understood that this was a request for tea. Staff also used tools such

as objects of reference and visuals to support good and effective communication with the resident.

The inspector did not meet with any resident representatives but saw from records that there was regular and consistent contact between the service and representatives. Representatives had also been invited by the provider to submit feedback on the service to inform the annual internal service review. The feedback on file was positive with the service rated as four and five with five being the highest possible score.

While the resident may not have provided explicit feedback on what life was like for them in the centre the resident presented as confident and relaxed in their home and with the staff on duty. The practice observed was as set out in support plans and protocols. For example, the inspector noted that staff parked the service vehicle in the location specified and were diligent in closing the entrance gates on their return to the house. The inspector saw that staff supervision was provided and verbal reminders were given to the resident when the resident accessed and used the stairs. The resident was seen to be wearing the footwear recommended for them as part of their falls prevention plan. However, the design and layout of the house remained unsuited to the assessed needs of the resident. The provider explained the reason for the delay in the relocation to a more suited premises. The provider was confident that the relocation would be completed within the revised requested timeframe. The house was comfortable and nicely personalised with family photographs.

In the interim there were controls to ensure the resident could use the stairs safely such as the supervision and verbal reminders mentioned above. The resident had not fallen on the stairs since the last inspection. However, records seen by the inspector indicated there had been inconsistency in the use of a device designed to alert staff to the fact the resident was up during the night and potentially approaching the stairs. Better oversight of the consistent use of this device was needed to ensure and assure the resident's safety. In addition, better correlation was needed between different risks to resident safety and how they were managed. For example, short periods when staff were unable to supervise the resident was not referenced in relation to preventing falls.

Because the service had not moved to the proposed new location the house was still without fire-resistant doors at first floor level. The provider assured the inspector that the new house would be fully complaint with the requirements of Regulation 28: Fire Precautions.

The resident received an individualised service and there were many examples of how the resident’s rights were protected and promoted. However, there was too much ambiguity about how one specific care intervention was facilitated in the centre. The details of this and the need for robust assurance as to how a better and more appropriate balance could be reached between care that was deemed essential and resident rights will be discussed in the main body of this report.

In summary, there was evidence of improvement and of management, care and

support that was focused on the safety and well-being of the resident. However, there were actions outstanding in relation to the premises and fire safety and some evidence of residual inconsistency that impacted on the quality and safety of the service.

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

Capacity and capability

As stated in the opening section of this report it was evident that senior management, local management and other stakeholders such as safeguarding personnel had worked collaboratively and with the staff team to address the findings and concerns arising from the last HIQA inspection. However, while improvement was evident the inconsistency noted on this inspection demonstrated the need for ongoing robust local and senior management oversight.

The person in charge told the inspector that she maintained an enhanced presence in the house and a second administration office was available to facilitate this. This presence afforded the person in charge the opportunity to meet with the staff team and the resident and to observe the support and care provided. Senior management described plans to reconfigure some of its management structures. These proposed changes would reduce the number of services the person in charge had responsibility for.

Senior management described the management systems put in place since the last HIQA inspection to support the change and improvement needed in the service. This had included more regular and structured meetings and supervisions across all grades of staff. For example, the staff team completed supervision with the social care worker who was supervised by the person in charge who was then mentored by her line manager. Senior management and the person in charge were assured this enhanced period of supervision had been received positively.

The inspector saw that staff meetings had been attended by senior management and safeguarding personnel. There was evidence of open and transparent communication between management and the staff team of the concerns arising from the last HIQA inspection, the potential impact on the quality and safety of the service and, the change that was needed. This change included the importance of providing consistent support and following correct reporting procedures if concerns arose. The person in charge assured the inspector that following this period of enhanced supervision there were no barriers to staff reporting concerns.

The provider had also completed two unannounced reviews of the quality and safety

of the service since the last HIQA inspection.

There was evidence to support positive impact of the actions taken by the provider. For example, a reduced incidence of both behaviours that challenged and medicines errors was reported. Records were amended so that staff could report compliance with or any deviation from the support plan. However, there was still some lingering inconsistency and gaps. This highlighted the need for ongoing robust management and oversight. For example, the gaps in risk management systems and the ambiguity in relation to a particular care practice. The inspector highlighted the need for systems of oversight and review to better demonstrate how findings were verified so as to provide the best possible assurance.

The resident continued to receive an individualised service and there was one staff member on duty at all times. The night time staffing arrangement was a staff member on waking duty. This night time staffing arrangement helped to reduce risk that presented due to the absence of fire resistant doors and the residents increased risk for falls. The staff rota demonstrated consistency of staffing including where relief staff were employed. Staff working on a relief basis attended staff meetings and were included in the provider's programme of staff training.

The programme of staff training was responsive to the needs and the changing needs of the resident and new risks arising such as COVID-19. The majority of staff had completed training in falls prevention and other clinical training; further training was planned. All staff working in the centre had completed training in hand hygiene, infection prevention and control and how to correctly use PPE (Personal Protective Equipment). Refresher training for staff in safeguarding residents from harm and abuse will be referred to again in the next section of this report.

Regulation 15: Staffing

Staffing levels and arrangements were based on the assessed needs of the resident and any associated risks. The staff rota showed the staff on duty each day and the hours that they worked. The staff rota demonstrated consistency of staffing was considered including where relief staff were employed. Nursing advice and support was provided as needed.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to a programme of training that was relevant to their role and that also reflected the assessed needs of the resident. The provider had systems for the formal and informal supervision of all grades of staff and adjusted these to meet the

specific needs of the service.

Judgment: Compliant

Regulation 23: Governance and management

There was evidence of improved management and oversight. However, there was still some lingering inconsistency and some gaps. This highlighted the need for ongoing robust management and oversight. For example, the gaps in risk management and the ambiguity in relation to a particular care practice. These gaps and this inconsistency impacted on the appropriateness, safety and quality of the service provided. Systems of oversight and review needed to better evidence how findings were verified so as to provide the best possible assurance.

The provider needed to progress and finalise the replacement of one house with accommodation suited to the resident's assessed needs.

Judgment: Substantially compliant

Quality and safety

The provider had responded robustly to the concerns arising from the last HIQA inspection. The provider had taken action to promote understanding of the importance of consistent support and care to resident health and well-being. The provider had clarified for staff reporting procedures and structures where concerns arose or where the resident themselves led support that was not consistent with their plan. However, there were still some gaps and some inconsistency that impacted on the quality and safety of the service such as in managing risk and balancing resident rights with the provider's duty of care.

As stated in the opening section of this report the resident had experienced a recent period of ill-health. The resident had recovered well. The care the resident needed including monitoring and oversight by staff to prevent a reoccurrence was clearly referenced in the resident's healthcare plan. Training had been provided to staff so that they had the skills and knowledge to identify possibly signs of illness. There was documentary evidence of regular and ongoing consultation with clinicians such as the resident's general practitioner, speech and language therapy, occupational therapy and hospital based services. There was evidence of collaborative MDT (multi disciplinary team) working that recognised the resident's assessed needs and, the use of specialised hospital based advocacy services.

Nursing advice and support was available from within the provider's own resources and had been utilised to inform the review of the service and to support staff in their

practice. For example, a comprehensive review of medicines management practice and of the resident's healthcare needs and plans had been completed.

Management and staff liaised closely with family and kept them informed of changes and concerns arising. For example, the residents representative was aware of the planned relocation to a more suitable property and was reported to be very happy with this planned move.

The resident had an accessible personal plan based on visuals and photographs. This plan mirrored the plan used by staff. The plan outlined how the support and care provided aimed to keep the resident safe and well but also develop their skills and independence and to enjoy a good quality of life.

Further to the concerns arising at the time of the last HIQA inspection the provider had completed a safeguarding investigation of concerns and allegations arising amongst the staff team. The provider had liaised with HIQA and with statutory safeguarding authorities in relation to the findings. The investigation had concluded that abuse had not occurred. The actions taken by the provider and discussed in the previous section of this report reflected recommendations made further to this safeguarding review. These actions included re-familiarising staff with the providers safeguarding procedures, reporting responsibilities and procedures. Staff were reported to be open to the learning and to the change needed.

However, based on records seen and discussion at verbal feedback of these inspection findings, all staff had not completed refresher training in safeguarding in the format required and intended by the provider as part of it's governance and management improvement plan.

There was scope to improve and strengthen risk management systems. For example, records seen indicated a pattern of occasions where the falls alert monitor had not been activated. The person in charge said this had been addressed with staff. However, there had been a further recent occurrence so better oversight and management that improved and assured consistent use and resident safety was needed. In addition, better correlation between different risks and their control was needed. For example, staff recorded occasions when they locked the main door for the safety of the resident when they were not in a position to supervise the resident for short periods. However, these periods when the resident was not supervised, the possible increased risk for an unsupervised fall and how to control this was not referenced in the falls prevention risk assessment and plan. The resident's risk for a fall was inconsistently scored in records seen and varied from a minor to a moderate risk. Better clarity was needed in the controls specified in an active safeguarding plan. The recorded controls did not accurately reflect the controls described to the inspector. This did not provide assurance that there was clarity and clear guidance on the controls.

There was awareness of what constituted a restrictive practice and systems for sanctioning and reviewing their use. There was also evidence that resident rights were respected and promoted. For example, the resident had been introduced to the provider’s internal advocacy network and since the last HIQA inspection the

resident had secured access and control of personal monies. However, while staff had the option of a restrictive practice (chemical intervention) to facilitate the delivery of a specific care intervention, staff instead sought to deliver this care at night while the resident slept on a couch having been guided there by staff. There was an explicit protocol in place setting out the location and the procedure to be followed by staff. While the inspector acknowledged the challenge, assurance was needed as to how this practice was more advantageous to the resident. It was not robustly demonstrated how the provider assured itself the protocol and the delivery of care while the resident was asleep, care that the resident did not ordinarily consent to when awake, was not covert and did not restrict the resident's rights such as their right to give consent, to privacy, dignity, their right to go to bed and, respect for their expressed will and preference. There was too much ambiguity on discussion of this practice as to the resident's state of alertness and awareness during this process. The inspector was not assured this practice and the supporting protocol was the most supportive care that could be achieved with and for the resident.

There were other impacts of this practice that needed to be considered by the provider such as the impact on the resident's night-time routines and sleeping patterns. Records seen by the inspector indicated that it could take staff up to six nights to complete this care intervention. Following verbal feedback of the inspection findings the inspector was assured the provider understood the limitations and consequences of this practice in the context of supportive care and resident rights. Following the inspection, the provider confirmed a preliminary meeting had been held to review this practice.

The house was still not adequately fitted with doors designed to contain fire and its products. This increased the risk of fire and its products such as spoke spreading in the event of fire. The premises was fitted with emergency lighting, a fire detection and alarm system and fire-fighting equipment. The inspector saw documentary evidence of their inspection and testing at the prescribed intervals. Staff undertook regular simulated evacuation drills with the resident including drills that replicated night-time conditions. There were no reported obstacles to the evacuation of the resident and good evacuation times were recorded.

Regulation 10: Communication

The personal plan provided guidance for staff and others as to how the resident communicated their needs and wishes and any additional support needed to ensure effective communication. Staff were seen to utilise tools such as a visual schedule to discuss and agree daily routines and activities. The inspector saw that the resident and staff communicated effectively with each other.

Judgment: Compliant

Regulation 12: Personal possessions

Management confirmed that the provider had, on behalf of the resident, received and assumed control of monies belonging to the resident but held by another authority who had previously provided a service to the resident. The personal plan set out how staff sought to support the resident to have financial independence, to access, enjoy and benefit from their monies.

Judgment: Compliant

Regulation 13: General welfare and development

There was ongoing vigilance to the possible risk posed by COVID 19. However, the inspector saw that the resident was out and about with staff each day. Family and staying connected to family was formally integrated into the plan of support and continued to be an important part of the resident's weekly routine. Staff sought to develop the resident's skills and the resident's participation in the daily routines of the house.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the house was not suited to the mobility needs of the resident. Clinical review had established that the resident was at risk of serious injury from a fall on the stairs due to intrinsic deficits in function that were likely to deteriorate with age. Facilities such as an accessible bathroom had also been recommended. The provider's plan to relocate to an alternative property within a specified time frame was delayed.

Judgment: Not compliant

Regulation 26: Risk management procedures

There were gaps and inconsistencies in the systems for responding to and controlling risks that had the potential to compromise resident safety. For example, there had been occasions when a falls prevention device had not been activated. In addition, better correlation was needed between different risks and their management such as the impact on the falls prevention plan of periods when staff

were not in a position to provide the resident with the supervision specified in that plan.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The house was not adequately fitted with doors designed to contain fire and its products. This increased the risk of fire and its products such as smoke spreading in the event of fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plan was based on an assessment of the resident's needs. The plan was updated to reflect changes in needs and circumstances. The personal plan was available to the resident in a format that was accessible and meaningful to them. The plan addressed the residents' needs in a holistic manner, for example their health needs but also their social, developmental and emotional needs. The provider had taken action to promote the consistency of the support provided.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident health and well-being and had completed additional training so that they had the knowledge and skills to do this. While further intervention was planned there was documentary evidence the resident had access to the clinicians that they needed so as to enjoy good health. The inspector did highlight the unnecessary duplication of healthcare plans.

Judgment: Compliant

Regulation 8: Protection

The provider had taken comprehensive action to provide assurance residents were protected from the risk of harm and abuse. However, all staff had not completed

refresher training in safeguarding in the format required and intended by the provider as part of its governance and management improvement plan.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector was not assured a specific care practice and it's supporting protocol achieved an appropriate balance between providing care and respecting and promoting resident rights. There were other impacts of this practice that needed to be considered by the provider such as the impact on the consistency of the resident's night-time routines and sleeping patterns.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not 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 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for The Abbey OSV-0004761

Inspection ID: MON-0033780

Date of inspection: 06/04/2022

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The service provider will ensure that the following actions are taken to achieve compliance with Regulation 23: Governance and management: • A full, comprehensive review of a risk in relation to falls is in progress to address gaps and inconsistencies in relation to a particular care practice and to provide assurances on the appropriateness, safety and quality of service provided to the resident. (See below under Risk Management for further plan in relation to this action). [31/05/2022] • A suitable alternative premises has been identified to meet the resident's long-term needs; therefore, providing a home to him, which will be designed and laid out to meet his current and anticipated future needs. Please refer to actions relating to Regulation 17 as outlined below. [01/09/2022] The PIC will implement a structured monitoring/over-sight system to ensure that the service provided is safe, effective and of a high quality; with the persons supported at the fore-front at all times.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The service provider will ensure that the following actions are taken to achieve compliance with Regulation 17: Premises: • A suitable alternative premises has been identified to meet the resident's long-term needs; therefore, providing a home to him, which will be designed and laid out to meet	

his current and anticipated future needs.
o OT assessment has been carried out identifying the type of housing the resident requires; as per his assessed needs – Complete.
o The service provider has identified a suitable bungalow for the resident; and is committed to working with the local Housing Authority to facilitate the purchase and renovation of the property, as per the aforementioned OT report.
o Renovations to the property will be made, as per QS & OT recommendations; to ensure the premises adheres to best practice in achieving accessibility, as per the residents' needs. The premises will be equipped with assistive technology, aids and appliances as recommended by OT; to promote the full capabilities and independence of the resident.
o Revised date for transition to new premises [01/09/2022]

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The service provider will ensure that the following actions are taken to achieve compliance with Regulation 26: Risk management procedures:

• Corrective action will been taken following incidents where a falls prevention device had not been activated to ensure consistency amongst the staff team for management of same – [31/05/2022]
• A comprehensive review of the falls risk assessment will be completed to include the impact on the falls prevention plan during periods when staff are not in a position to provide the resident with direct supervision. Additional controls will be explored and implemented as required.– [31/05/2022]
• A review of the correlation between risks will take place to ensure that risks, which are linked or share control are referenced in each individual assessment and all factors are considered. – [31/05/2022]
• The PIC will ensure that the risk assessment in place regarding falls is reviewed regularly; and corrective actions required are implemented in a timely manner to ensure residents safety. – [31/05/2022]

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The service provider will ensure that the following actions are taken to achieve

compliance with Regulation 28: Fire Precautions:

• As outlined above Regulation 17: Premises will be progressed within the next 4-month period; the fire doors/ door closers in one premises will not be progressed as a result.
• A comprehensive fire safety risk assessment is in place for this service area, outlining comprehensive existing controls in place to ensure adequate precautions against the risk of fire within the service area in the interim. This risk assessment is reviewed at least six-monthly.
• In the interim, arrangements are in place to ensure the maintenance of fire equipment installed, regular fire drills are carried out with the resident, and all staffs' training in Fire Safety is up to date and refreshed as required.
• Fire doors are installed in the second premises within the designated center; and fire doors are fitted with self-closing devices. [01/09/2022]

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The service provider will ensure that the following actions are taken to achieve compliance with Regulation 8: Protection:

The staff team will complete refresher Safeguarding of Vulnerable Adults training. The DO will also complete a team specific safeguarding briefing to provide assurance that the resident is protected from the risk of harm and abuse. All trainings completed will be uploaded to the staffs training records as per provided procedures. [30/06/2022]

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The service provider will ensure that the following actions are taken to come into compliance with Regulation 9: Residents Rights:

• A comprehensive review will be carried out on a specific care practice and its supporting protocol to ensure an appropriate balance is achieved between providing care and respecting and promotion resident's rights. This review will be completed by a multidisciplinary team and take into consideration the impacts of this practice such as the impact on the consistency of the resident's night-time routine and sleeping patterns. [30/06/2022]
• Where restrictive practices need to be considered the team will review all possible practices and ensure to consider the resident's rights and balance in line with the least

restrictive practice while ensuring the residents safety. [30/06/2022]

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	01/09/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	01/09/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	31/05/2022

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	01/09/2022
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	30/06/2022
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where necessary, to decisions about his or her care and support.	Not Compliant	Orange	30/06/2022