Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Centre 3 - Cheeverstown House Residential Services (Active Age/Senior Citizens)
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	31 March 2022
Centre ID:	OSV-0004926
Fieldwork ID:	MON-0030622

About the designated centre

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

This designated centre provides 24-hour care, seven days per week, for up to 19 male and female adult residents. The centre is located on a residential campus in South Dublin. The centre consists of four residential houses primarily caring for the active age and senior citizen group who have an intellectual disability. The range of intellectual disability in this group covers all ranges from mild, moderate to severe/profound in nature. Some individuals have physical and sensory disabilities also. One of the houses has seven bedrooms, two houses have six bedrooms and one house has three bedrooms. There is a full-time person in charge and the front-line staff are primarily made up of clinical nurse managers, staff nurses, care assistants and housekeepers. The service has access to a number of accessible vehicles to facilitate transport to appointments, social outings and activities in the community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 31 March 2022	09:40hrs to 17:15hrs	Gearoid Harrahill	Lead
Thursday 31 March 2022	11:30hrs to 17:15hrs	Michael Keating	Support

What residents told us and what inspectors observed

During this unannounced inspection, the inspectors had the opportunity to meet with 13 of the 15 residents living in this designated centre, as well as observe some of the support routines and interaction between residents and their support staff. One resident was not comfortable with visitors entering their house at the time of inspection and this was respected.

Residents were supported across four houses on a campus setting. One person lived in their house alone and the other three houses could accommodate up to six people. As part of their strategy to transition out of the campus accommodation, the service provider has closed these houses to new admissions and referrals. The provider was in the process of conducting assessments of support needs, identifying premises and attaining funding, to provide appropriate care and support to residents in accommodation in the community which was more suitable to their needs. At the time of inspection, one resident was preparing to move to a new apartment in the coming weeks. This resident was looking forward to the change, and inspectors were provided evidence of them being consulted in the arrangements, and pictures of them visiting the new location.

The current living arrangements for the residents in shared houses had been identified as being unsuitable for their needs. There had been an ongoing trend of incidents in which residents' presentations during times of distress or anxiety had unintentionally had an impact on their peers, upsetting them, made their home loud and over-stimulating, or disturbed their sleep at night.

However, inspectors found evidence indicating how the support team and management were taking this ongoing risk seriously and were making efforts to maximise opportunities to get out of the house to socialise, travel or engage in meaningful activities as part of residents' routines. Some examples of these included attendance at day services or trips to the cinema, pub, garden centre or library. On the day of the inspection two residents went out for a trip to the seaside to enjoy the sunny weather. Another resident was observed socialising in the central canteen area of the campus. One resident was preparing to visit family. Access to the community was optimised with availability of multiple accessible vehicles assigned to the designated centre, as well as staff to drive them.

The risk related to residents upsetting one another was also mitigated by a staff team who displayed a good knowledge of residents' likes and dislikes, daily routines and personalities. Inspectors observed natural, friendly and patient interactions between staff and residents. Examples of good interactions observed by inspectors included appropriate intervention when one resident was getting upset by one of their peers, and staff agreeing a compromise with residents when different people wanted different shows on the living room television. Appropriate and personal support was also witnessed with staff supporting residents with dressing, transporting, smoking and communication. Overall residents communicated that

they were happy in their home and appeared content and comfortable in their environments, and were facilitated to spend time outside their home with appropriate and familiar staff support. Inspectors observed that staff responded to calls for assistance in a timely yet unhurried fashion.

Some areas of the residents' homes required improvement in general upkeep, and the premises overall was dated and assessed as no longer suitable. However, effort was evident in ensuring that residents' bedrooms and living rooms were appropriately decorated, clean and personalised while these houses were still in use. Equipment such as wheelchairs, hoists and accessible bathroom features were available and in working order.

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

Capacity and capability

The inspectors found evidence to demonstrate that the provider had suitable governance and management arrangements in place to ensure the service was appropriately resourced for the number and changing needs of residents, and that areas in need of enhancement and development were proactively identified with appropriate action taken or planned.

The provider supplied evidence during the day to demonstrate how the provider was engaging with relevant external parties to progress their commitment to move on from congregated settings. The provider had trended and analysed the ongoing concerns related to residents who were incompatible with each other or with shared living in general, as part of their assessment of community support needs. Provider stakeholders met regularly to discuss the latest updates and challenges towards the achievement of their goal, and set out next steps to transition people while also ensuring the potential premises, staffing resources and access to health services and social opportunities remained suitable for their assessed needs. The provider was taking measures to ensure that staff were also prepared in the relevant skills for their role in the future of resident support.

The provider was engaged in ongoing evaluation of the quality and safety of the service. They had completed their annual review of the centre as well as a six-monthly regulatory audit published in January 2022. The inspectors reviewed these reports and found them to be detailed, with clearly identified actions, as well as follow-up notes by the person in charge commenting on objectives completed or in progress. Inspectors found evidence that the actions in these reports had been implemented in practice, and many of the areas identified by the inspectors as in need of improvement had also been identified by the provider or person in charge in their own reviews. Some improvement was required to ensure that the annual

review was composed in consultation with the residents and their representatives to reflect their feedback and commentary; this was identified in the six-monthly review which followed.

A new full-time member of staff was due to start in the centre on the week following this inspection, leaving 0.5 whole time equivalent posts short of a full complement of staffing resources in the service. Staff spoken with and observed on inspection were knowledgeable on centre processes, residents' needs, personalities and communication styles. The benefit of having familiar staff with whom residents had an established trust and rapport was evident, in the interactions observed in the houses and when getting people ready for outings. Inspectors reviewed planned and actual rosters for a sample of three months, and found them to clearly identify who worked in the centre and where changes had occurred due to absences. While there had been a high amount of relief and agency use in this centre, there had been a significant improvement since the previous inspection in the consistency of familiar personnel when using these arrangements, to mitigate the impact on support continuity for residents.

Inspectors found evidence demonstrating that safe recruitment practices were in effect and that the number, qualifications and skill mix of staff was appropriate for the number and assessed needs of residents. Inspectors found evidence that the staffing resources were adapted based on changes in these needs, such as increasing nursing support in the service. Staff had access to a comprehensive suite of training programmes as part of their continuous professional development. This included training specific to the needs of the individual houses, including dysphagia, dementia, palliative care, diabetes and epilepsy. While records indicated that a number of staff were overdue to attend refresher courses in areas such as fire safety, safeguarding of vulnerable adults, positive behaviour support and safe moving and handling, there was evidence indicating that refresher sessions in these courses had been booked for the relevant personnel.

Inspectors reviewed a sample of complaints raised by residents and their representatives, and found that these had been responded to in a timely fashion, with notes on the actions taken and how the provider and the complainant reached a satisfactory outcome.

Regulation 14: Persons in charge

The person in charge demonstrated a good knowledge of their role under the regulations. They were full-time in the role of person in charge and were suitably qualified and experienced in management of a healthcare and social care setting.

Judgment: Compliant

Regulation 15: Staffing

The service was appropriately resourced with a number and skill-mix of staff appropriate to residents' assessed needs. While the service regularly used relief and agency arrangements, there had been a significant improvement of the continuity of residents support when these resources were deployed. A complete and accurate record of the times and locations people worked in the service was available for review. Staff personnel files reviewed contained all information required under the regulations including evidence of qualifications and Garda vetting.

Judgment: Compliant

Regulation 16: Training and staff development

Staff members were provided a comprehensive suite of training including training in supporting the assessed need of residents living in this designated centre. While a number of staff were overdue for refresher sessions in mandatory training, inspectors found that this had been identified by the provider with sessions booked for staff. Staff were supported to attend supervision and performance management sessions with their respective line mangers in accordance with provider policy.

Judgment: Compliant

Regulation 19: Directory of residents

The service provider maintained a directory of the current residents in the designated centre, including all information required by the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The service provider had suitable and effective oversight arrangements to be assured of the quality of service and to be advised of challenges and risks in the individual houses. The provider and person in charge demonstrated a proactive approach to identifying and taking action to resolve areas in need of development, and inspectors found examples of these actions being implemented in practice. Many of the areas in need of development identified by inspectors on this visit had been identified by the provider in their own reviews and audits. The provider had

completed their six-monthly and annual reviews of the quality and safety of the service, with some development required to ensure they were composed in consultation with residents and their representatives. The provider was aware of the specific circumstances of the risks related to residents' incompatibility with shared living, and time bound actions were in progress to secure the resources, funding, assessments and premises to ensure effective and safe de-congregation of this designated centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The provider had responded to complaints in a timely fashion and in accordance with centre policy. A log of the details of complaints, and actions take in response to same, were available for review.

Judgment: Compliant

Quality and safety

Overall the residents were receiving a level of support which was appropriate to their assessed needs. The provider and front-line staff were taking suitable measures to ensure that residents' choices were respected, and that they were protected from instances of potential abuse. While the provider had plans in place to source new accommodation more appropriate to meeting residents' needs, until this was done the identified compatibility challenges had continued to have a negative impact on residents' wellbeing in the shared houses.

Inspectors reviewed a sample of residents' personal support plans and found them to be detailed and based on a comprehensive and evidence-based assessment of health, personal and social care needs. Inspectors found evidence that these plans were recently reviewed and audited by the person in charge with clear actions identified in regard to each individual plan. In addition to the accuracy and completeness of the plans, the person in charge had also set out actions to make plans more person-centred. Examples of this included ensuring that the staff guidance was appropriate an respectful in its wording, and emphasising the independence levels of residents, particularly in supports with mealtime, personal hygiene, communication and intimate support. The person in charge had also identified that plans were not consistently available in an accessible format for residents; at the time of inspection, the person in charge's audit notes indicated that this action was complete for 50% of the personal plans and in progress for the other half. Evidence was available of regular review of plans with appropriate input from

the multidisciplinary team.

Inspectors found evidence indicating that residents had been consulted on matters related to their support. For example, some residents had opted not to participate in national screening programmes for which they were eligible. Residents' choice and privacy was observed being respected during the day, including staff explaining who the inspectors were when they arrived at their homes. Examples were observed during the day of staff giving the residents space and time to make choices and decisions, including when they got up from bed, when they wished to have food or drinks, go out for a cigarette, watch television, go for a walk, or go on a day trip. Staff supporting residents to go out for the day were observed ensuring that residents were dressed for the weather and had what they needed, in a patient and respectful manner. Resident meetings took place in the designated centre, and one of the findings in the person in charge's review was that they required improvement in their frequency and topics discussed. This was evident in the minutes of recent meetings reviewed by inspectors. Residents were supported to raise issues, in the house or through their advocate, which were meaningful to them. For example, wheelchair users had commented that paths which were damaged or obstructed by vehicles impacted on their safe navigation, and actions were described of how this would improve going forward.

Despite the efforts that the provider, managers and front-line staff were making to ensure residents were active and spent time out of the house, there remained clearly identified compatibility issues in each of the shared houses, which was acknowledged by the provider. The majority of incidents recorded by the provider caused psychological distress to residents without intent by their peers, for example distress caused by loud vocalisations, banging doors, disturbing sleep or triggering anxiety. The provider was taking steps towards their objective to de-congregate the designated centre into smaller, community-based houses and apartments. While progress on this through 2021 had been limited, inspectors acknowledged that the provider is engaging with relevant external parties to coordinate the project, with one resident in the final stages of moving to a new location, who had been fully involved in decisions made in this process.

Inspectors reviewed investigations which had taken place in response to instances of alleged or suspected resident abuse or mistreatment. The scope and methodology of the incident review was detailed, done in a timely fashion and with immediate action taken to safeguard the residents pending the outcome of the review in accordance with the provider's policy on resident protection. Regardless of whether the allegation was substantiated or not following the investigation, the provider used the event as an opportunity to provide learning and development of practice going forward to avoid future incidents. Staff reported detailed notes at the start of the alleged incident to provide sufficient information for a thorough investigation. Staff followed their guidance, were aware of their responsibilities, and were facilitated to raise concerns if they were ever concerned of the wellbeing of the residents. Inspectors found evidence of other ongoing practices to ensure resident protection, including safeguarding plans to mitigate the impact of the assessed incompatibility with housemates. The spending of residents' money was routinely

reviewed to protect them against potential financial exploitation.

Overall the houses on the shared campus had been identified as no longer suitable to provide appropriate accommodation for residents and the provider was in the process of identifying suitable homes in the South Dublin region. While the design of the current houses were no longer suitable, inspectors observed that on the whole, effort had been made to keep them clean and nicely decorated. Resident living rooms and bedrooms were comfortable and personalised, with access to required equipment. Peeling or rusting surfaces, cracked or flaked flooring, exposed pipes, areas in need of repainting, and damage to the upholstery of some furniture had had an impact on the homely appearance of the centre, as well as an impact on the ability to clean and sanitise areas such as bathroom and kitchens. Notwithstanding this wear and tear, the front-line staff including housekeepers were diligent their duties in ensuring the houses were generally clean and free of malodour. Some improvement was required in the management of toiletries for residents who did not have private en-suites, as inspectors observed some examples in the houses of items such as creams, nail clippers and toothbrushes left behind in shared toilets and bathrooms. In reviewing resident equipment, one wheelchair was noted as being cleaned since its last use but was observed to be dirty with food on the seat and metalwork. Staff were observed following appropriate hand hygiene practices and were all wearing face coverings of a grade in line with current national recommendations for residential care settings.

Inspectors reviewed a sample of practices for the management, storage, prescription, administration and disposal of medicines in the designated centre. Residents' prescriptions were recorded with clear instruction and guidance, and staff spoken with presented a good knowledge of what the medicines were prescribed for. Medicines were appropriately stored, including being stored in refrigerators or double locked presses as per instructions. Audits were carried out to identify medication errors and develop learning from the findings. In a review of the administration records in one of the houses, inspectors found that the administration records had been pre-signed for times later in the day, rather than being recorded at the time of the resident taking their medicine. This practice is not appropriate and does not constitute an accurate record of the times and doses of residents receiving medication.

Regulation 17: Premises

The houses had been identified as no longer suitable to effectively meet the needs of the residents, and some areas were identified as in need of repair or maintenance. However, staff were fulfilling their duties in keeping the house generally tidy and ensuring that living rooms and bedrooms were comfortable and suitably decorated based on the preferences of residents.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had a policy and procedures for risk management in the service which included information required under the regulations.The provider maintained a risk register for the centre which included potential hazards and risk controls which were relevant and specific to the centre and its residents.

Judgment: Compliant

Regulation 27: Protection against infection

Staff observed good practices regarding hand hygiene and use of personal protective equipment. Some improvement was required in the management or storage of items which posed an infection control risk to service users, with observations including:

- Toiletries such as creams, nail clippers and toothbrushes left in shared toilet and bathroom spaces.
- Mops stored standing in dirty water buckets when not in use.
- Brushes stored behind bins and pipes when not in use.
- Some sterile equipment in stock which was past its date of expiry.
- Resident personal equipment which was not clean.

In addition, worn, torn, rough, cracked, peeling or rusty surfaces impacted on staff members' ability to effectively clean and sanitise some rooms and furniture in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Overall staff evidenced a good knowledge of medication management practices and all medication was appropriately stored, counted, and disposed of when no longer required. Inspectors observed instances in which staff had pre-filled the record of medicine administration which was due later in the afternoon and evening. This is a poor administration practice which results in inaccurate information and poses a risk to residents.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Inspectors reviewed a sample of support guidance on residents' health, personal and social care needs, and found them to be detailed, respectfully written and composed with input from the multidisciplinary team. Plans were updated based on changing needs of residents.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was a low level of use of restrictive practices in this centre, and for a sample of these measures, inspectors were provided evidence of how they were reviewed to authorise their continued use.

Staff were provided person-centred and evidence based guidance on avoiding and responding to incidents in which residents express anxiety or distress in a manner which poses a risk to themselves or others.

Judgment: Compliant

Regulation 8: Protection

Investigations which had taken place in response to allegations of abuse were detailed, conducted in accordance with provide policy and procedure, and were used as opportunities of learning and development.

There was evidence that the provider was taking steps to arrange more appropriate living arrangements for service users, and staff were following person-centred strategies in supporting low-stress environments and responding to incidents. Despite these measures, residents continued to be at risk of psychological distress and triggered anxiety without intent from their fellow residents when in the shared houses.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were consulted with and afforded choices in decisions and objectives which were meaningful to them, including people who soon to move to new accommodation. The frequency of resident meetings had increased, and inspectors observed good examples of how the privacy and dignity of residents was respected in their home. While effort had been made to keep residents busy and engaged outside of their house, assessed incompatibility of residents with their housemates continued to have a negative impact on many residents' lived experiences when in the shared homes.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Centre 3 - Cheeverstown House Residential Services (Active Age/Senior Citizens) OSV-0004926

Inspection ID: MON-0030622

Date of inspection: 31/03/2022

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: This designated centre will design an accessible document for service users to ensure feedback is captured from each resident. Family Feedback will be captured in the annual report for this designated centre. The quality and safety report will be reviewed and redesigned to reflect and include service users input. Managers reviewing an easy read document folder to help service users communicate their feedback and making informed decisions.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Floor covering in three locations will be replaced. All rusted pipes will be replaced or repaired. Missing tiles in one location will be replaced. Cracked tiles in one location will be replaced. All areas identified for painting will be completed. Kitchen cabinetry will be refurbished and replaced where need identified.	

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
From the 31st of March
All resident's belongings are now kept personalized and are held in their own rooms.
Any out of date products have been disposed of and labels and dates are placed on items opened and held in the residents own room.

Staff practice highlighted and addressed at staff team meetings

Equipment cleaning schedules have been revised and updated for both day and night duty staff and same are now in a separate folder in each location in the DC. All staff are aware of the importance of same.
Managers review these practices during their daily supervisions and same are now added to their daily supervision schedule.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Cheeverstown Medications Administration & Management Policy and procedure guides staff practices.
Medication Error Form completed on the day of inspection with staff and actions identified.
Medication Management training refresher was completed.
A medication dispensing review has commenced by the managers with the staff to help support and guide on the safe administration of medication in line with our policy through our audit tool.
Cheeverstown's guidance is for staff nurses to complete the on-line module on Safe administration of medication on Hseland as an additional support and guidance to them.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The safeguarding report for DC3 Jan 2022 highlights the incompatibility of individuals living in the centre and the number of incidents which have been reported between individuals.
Compatibility assessments have also been completed to advise of suitable future living options for service users. A plan for transition of 10 service users in 2022, from Cheeverstown centre, is in process, which prioritises service users who live in DC3.

Risk controls in effect to safeguard residents in their home:

• Residents are educated on skills of self-care and are supported to understand what to do to protect themselves.
• Staff are trained to recognize and report all forms of abuse.
• All incident, allegation or suspicion of abuse or neglect are investigated and a safeguarding plan put in place with appropriate action where a resident is harmed or suffers abuse.
• All residents have personal plans which assess the person's needs and wishes in relation to intimate care and positive support in a manner that respects the resident's dignity.

Individual Safeguarding plans are reviewed monthly by the local team/safeguarding team to assess their effectiveness
The Safeguarding committee group meet quarterly to review updated organizational data in relation to safeguarding incidents and formulate actions in relation to areas which have high levels of reporting to safeguarding.

Relevant stakeholders meet to discuss and make progress on timelines for the suitable transition of the residents for "Time to Move on Planning "for the designated centre via various communication platforms which include:

• Weekly meeting with D3 PIC (transition co-ordinator) and the local transition team.
• MDT meetings are held fortnightly
• Admissions. Transfers and discharges meeting once a month
• Time to move on Steering group which meets once per quarter or sooner if required for updates, information sharing and decision making.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Increase frequency of resident's meetings which in turn will enable them to express their will and preference and what a meaningful life is to them.

Reviews of residents daily and weekly plans to help create more dialogue and explore their preferences.
Increase frequency of supported transport to access their community and create new opportunities.
Increased opportunity for residents whom wish to explore opportunities outside their home during the day.

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.	Substantially Compliant	Yellow	29/07/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	29/07/2022
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	Substantially Compliant	Yellow	30/09/2022

	representatives.			
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	31/03/2022
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	31/03/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2023
Regulation	The registered	Substantially	Yellow	29/07/2022

09(2)(b)	provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Compliant		