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:	Ralahine Apartments
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	09 March 2022
Centre ID:	OSV-0005232
Fieldwork ID:	MON-0034457

About the designated centre

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

This centre is located in a town in Co. Clare and provides a residential service for a maximum of three residents who are all over the age of 18 years. The centre is comprised of three separate ground floor apartments in an apartment complex. Each resident has their own apartment shared with the staff member supporting them by day and by night. Each apartment provides the resident with their own bedroom, some en-suite facilities, a main bathroom, and a combined kitchen and living area. There is a compact garden area to the rear of each apartment. The model of care is social and a staffing presence is maintained in each apartment at all times. The night time staffing arrangement is a staff member on sleepover duty in each apartment. Management and oversight of the centre is delegated to the person in charge supported by a social care worker.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 9 March 2022	10:15hrs to 17:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken to monitor the provider's compliance with the regulations and to follow up on the findings of the last HIQA (Health Information and Quality Authority) inspection undertaken in May 2021. The registration of this centre had been renewed in 2021 with an additional condition attached compelling the provider to address a specific non-compliance within a specified time-frame. The provider had applied to vary and extend that time-frame.

The primary finding of this inspection was the failure of the provider to ensure governance arrangements put in place ensured consistent management and consistent oversight of the service. The provider has failed to demonstrate full-compliance with Regulation 23 Governance and Management over the course of four consecutive HIQA inspections. Inconsistency in the management structure resulted in an absence of continuity and failure to satisfactorily progress quality improvement actions. The inspector found disorganisation, an absence of records and gaps in systems for underpinning and verifying the quality and safety of the service provided to residents. There were repeat findings. For example, better oversight and purposeful analysis of incidents was still not robustly evidenced. Findings will be discussed in detail in the next two sections of this report.

The provider had reduced the overall occupancy of the centre and each resident now had their own apartment. This addressed previous repeat HIQA findings of resident needs that were not compatible in a compact shared living arrangement. Based on records seen and staff spoken with the frequency and intensity of behaviour related incidents was much reduced. However, the reliability of these records will be discussed again in the main body of this report. Based on what the inspector observed further timely behaviour support and guidance for staff on how to respond to behaviour that challenged was needed.

There were elements of the provider's infection prevention and control measures that needed to be reviewed and comprehensively addressed. For example, there were reported challenges to the use by staff of the required higher specification FFP2 face mask and some practice observed by the inspector was not in line with current national guidance. Clear plans and protocols were not in place for responding to symptoms reported by residents that may have been indicative of COVID-19 or other respiratory tract infections. The absence of such plans and protocols caused some concern at the start of this inspection. This was highlighted to and addressed by management so that the inspection could proceed safely without the need for additional infection prevention and control measures.

Overall, the process of risk identification, management and escalation of risk was fragmented and not purposefully utilised to assure the operation of the service and to progress and address matters arising such as the reported challenges to FFP2 mask use.

Once assurance was provided to the inspector that there was no active infection risk in the centre, the inspector visited and met with each resident and their supporting staff member in their own apartment. One resident did not wish to engage with the inspector, clearly communicated this and the residents choice was respected. Overall, the resident was reported to struggle with the presence of staff and others in the apartment which they viewed as their home. This will be discussed again in the main body of the report. One resident communicated by means other than non-verbal communication. The resident welcomed the inspector into their apartment by expression and gesture. The inspector saw how the resident by gesture requested assistance to put on a particular television programme. The resident supported by staff was assisting in the preparation of their evening meal.

The inspector is well known to one resident from previous inspections of this centre. The resident had a planned visit to home on the afternoon of the inspection. The inspector waited and met with the resident on their return. The resident had a good chat with the inspector. There was discussion of home and family. The resident was looking forward to receiving new specialised seating and a new wheelchair that had been recommended for them following a recent occupational therapy review. The resident said that they were happy living on their own in the apartment. The resident told the inspector that they liked to maintain contact with the peer they had previously lived with and said they had enjoyed two such visits supported by staff. The resident said they were happy to have seen their peer and the visits had gone well. The resident told the inspector they could tell staff or the person in charge if there was something worrying them. The resident said they were happy with the support they received in response.

Observation of practice and engagement with residents did identify and confirm the need for improvement. However, it also provided assurance that residents were well, had access to their local community, to home, family and peers and access to healthcare services.

The inspector did not meet with any resident representatives. The person in charge who was recently appointed to the role had met or spoken with all representatives. The person in charge had also issued questionnaires to representatives seeking feedback that would be used to inform the annual review of the service for 2021. One questionnaire had been returned and was shared with the inspector. The feedback provided was positive.

The next two sections of this report will present the findings of this inspection in more detail 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 the primary finding of this inspection

was the failure of the provider to ensure governance arrangements were in place that ensured consistent management and consistent oversight of the service was maintained. There had been inconsistency in the local management structure. The impact of this inconsistency was evident in the level of disorganisation found by the inspector that left the service poorly equipped to effectively respond to this unannounced inspection or to any other form of structured review.

Since May 2019 four different persons have undertaken the role of person in charge of this designated centre. In 2021 three changes were made due to planned and unplanned absences. This inconsistency was exacerbated further by changes to the role of social care worker, a role designed to practically support the person in charge in the management and oversight of the service. While changes may have been outside of the control of the provider the arrangements put in place in response did not ensure continuity of governance and the satisfactory progression of quality improvement plans. This limited the provider's ability to achieve and sustain in this centre a better level of compliance with the regulations. There were repeat themes between the findings of this inspection and the previous HIQA inspection such as outstanding staff training, incorrect use of PPE and a fragmented and inconsistent approach to managing risk.The provider had addressed the matter of resident needs that were incompatible but that was further to regulatory action taken by HIQA and the attachment of a condition to the renewal of registration of this centre.

In addition to the inconsistency persons participating in the management of the centre were not always supported by working arrangements that allowed them to effectively fulfil their substantive role and responsibilities. For example, the current person in charge was appointed as person in charge in mid to late December 2021 but advised the inspector they had to continue in their previous role until mid-January 2022. In addition, staffing contingencies and arrangements meant that both the person in charge and the social care worker were on occasion required to work as front-line staff.

Access to the records needed to inform these inspection findings and to verify the quality and safety of the service was particularly challenging. The main office was located in one apartment. On arrival, the inspector saw it was a disorganised space and there was a lack of clarity as to where records needed by the inspector could be accessed. During the inspection it transpired a resident had access to this office and to records and the completeness and security of the records was not assured. The person in charge told the inspector that on appointment she had struggled to find records, it was unclear where records were maintained and where they could be accessed. The person in charge had commenced the process of reviewing and creating records and was uploading most records to an electronic record sharing system that could be accessed by all staff. However, there was still gaps and a lack of clarity as to what was to be available in soft copy, in hard copy or both. For example, the records of simulated evacuation drills. Hard copy records were incomplete and soft copy records were not always available where gaps were identified by the inspector. For example, explicit assessments of risks that presented. Regardless of whether the provider chooses to utilise hard or soft copy records, the records as specified in the regulations must be in place and must be available for inspection. Arrangements must be in place for restricting access to

records and for ensuring their safe and secure storage.

The provider had quality assurance systems. For example, the person in charge confirmed she was in the process of completing the annual review of the service for 2021. This was to be completed by the end of March 2022. The provider was also completing the six-monthly unannounced reviews as required by the regulations. When the inspector reviewed the report of the most recent six-monthly review completed in late January-early February 2022, the inspector saw the findings of that internal review were very similar to the findings of this HIQA inspection. The reviewer reported the impact of change including changes to the management team. The reviewer found there were outstanding quality improvement actions from the last internal review completed in September-October 2021. The reviewer also found gaps in documentation and an absence of documentary evidence to verify actions taken. An extensive quality improvement plan issued from that internal review with improvement actions issued for all eleven regulations reviewed. This included actions to being about improvement in governance and management, risk management, infection prevention and control and staff training.

The person in charge was clearly committed to regulatory compliance and the provision of a safe, quality service to residents. The person in charge confirmed she was working on the internal quality improvement plan. The person in charge acknowledged the support and the opportunity for learning afforded to her by the internal reviewer. The person in charge confirmed that they had access as needed to their line manager. The person in charge was very open to these HIQA inspection findings. However, the person in charge was also very aware of the body of work needed to ensure and assure the quality and safety of this service and to achieve and sustain a satisfactory level of compliance with the regulations. The person in charge does not have sole responsibility to ensure the provider demonstrates satisfactory compliance with the regulations and standards. A comprehensive, consistent and collaborative governance response was needed to internal and external action plans.

The provider while collecting data was not always effectively using that data to assure the quality and safety of the service and to bring about improvement. For example, in relation to assuring it had appropriate staffing arrangements. The person in charge confirmed staffing levels were always maintained but staffing contingencies were not always appropriate to the needs of the service. As stated above staffing deficits at times impacted on the governance and management arrangements. In addition, the majority of staff employed were reported to work in other designated centres or in other services and a limited number of relief staff with limited availability were employed. The requirements of these services and these staff had to be considered when staffing this centre. The person in charge told the inspector that staff had recently re-commenced the recording of instances of night-time disturbance. However, there was no evidence as to how this monitoring was analysed to inform and assure the appropriateness and safety for staff of this staffing arrangement.

The format of the staff rota had been improved. The rota showed the staff members

on duty by day and by night.

The person in charge and the social care worker did throughout the inspection seek to ensure the inspector had access to any records that were requested, this included records of training completed by staff. However, the records that were made available were not complete and did not reflect all staff listed on the staff rota. The records that were available indicated that while some progress had been made since the internal review there were staff employed with gaps in training. These gaps included training in medicines management, the management of actual and potential aggression and in infection prevention and control. There was a risk assessment and the person in charge described controls for staff working without medicines management training. A risk assessment was not in place for the other training that was outstanding. Training was planned but not until May 2022.

Regulation 14: Persons in charge

The person in charge was recently appointed to the role, worked full-time and had the skills, experience and qualifications needed. The person in charge was clearly committed to regulatory compliance and to the provision of a safe, quality service to residents. The person in charge was very open to these HIQA inspection findings and very aware of the body of work needed in this centre to achieve and sustain a satisfactory level of compliance with the regulations.

Judgment: Compliant

Regulation 15: Staffing

The provider needed to review the overall staffing arrangements and the staffing contingencies it operated in this centre for responding to planned and unplanned staff absence.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were employed with gaps in mandatory and required training. These gaps included training in medicines management, the management of actual and potential aggression and in infection prevention and control. Training was planned but not until May 2022.

Judgment: Substantially compliant

Regulation 21: Records

Access to the records needed to inform these inspection findings and to verify the quality and safety of the service was particularly challenging. There was a lack of clarity as to where records needed by the inspector could be accessed. Hard copy records were incomplete and soft copy records were not always available where gaps were identified by the inspector. Appropriate arrangements were not in place for restricting access to records and for ensuring their safe and secure storage.

Judgment: Not compliant

Regulation 23: Governance and management

The provider failed to ensure governance arrangements were in place that ensured consistent management and consistent oversight of the service. There had been inconsistency in the local management structure. The impact of this inconsistency was evident in the level of disorganisation found by the inspector that left the service poorly equipped to effectively respond to this unannounced inspection or to any other form of structured review. Inconsistency resulted in an absence of continuity and a failure to satisfactorily progress quality improvement plans. This limited the provider's ability to achieve and sustain in this centre a better level of compliance with the regulations. The provider while collecting data was not always effectively using that data to assure the quality and safety of the service and to bring about improvement.

Judgment: Not compliant

Quality and safety

The requirement for two residents to share a compact living space in close proximity to each other had impacted on the quality and safety of residents' lives and had been a repeat HIQA inspection finding. As stated in the previous sections of this report the provider had reduced the overall occupancy of the centre and had ceased the shared living arrangement.

Consequently, based on what the inspector read and was told the overall incidence of behaviours that challenged had reduced. However, the reliability of records is referred to later in this report and based on what the inspector observed further

timely MDT input was needed to support resident's and to guide staff in the management of behaviours that challenged. The person in charge confirmed that residents had access to support from the behaviour support team and psychology and there was an active positive behaviour support plan. However, it was evident that a resident was struggling to understand the concept of and the workings of an apartment that they saw as their home but was also a designated centre and a place of work, this was resulting in new behaviours. The person in charge had submitted a referral for further input from the behaviour support team in December 2021 but this had not progressed. There were measures that the provider could have taken to reduce the challenge that presented for the resident and staff. The reduced overall occupancy of the service meant that an alternative space for the office was potentially available. The person in charge confirmed that this relocation was under consideration.

In addition, the inspector reviewed a protocol that had been put in place further to an incident that had occurred in late November 2021. The incident has been reported to HIQA and had been reviewed and investigated by the provider. However, the protocol lacked clear unambiguous guidance for staff and this had the potential to result in a re-occurrence.

Based on what the inspector observed, read and discussed measures for reducing the risk for the introduction of infection, for the prompt detection of symptoms, reducing the risk of transmission and for maintaining oversight of infection prevention and control measures were not robust. In one apartment the inspector saw that a staff member was wearing a face mask but not wearing the required FFP2 mask. This finding was in the context of a resident complaining of symptoms that may have been indicative of COVID-19 or another respiratory tract infection. The resident had accessed and was in the process of completing without staff supervision or assistance their own antigen test; the technique observed was not adequate to give a reliable result. There was no plan to guide staff on how to respond to such situations where a resident was reported to have a regular pattern of reporting such symptoms.

The provider had arranged for staff the recommended fit-testing of FFP2 masks. The inspector was advised that staff in general were challenged by the requirement to wear the FFP2 masks. While staff spoken with later in the day confirmed this they were all observed to be wearing a FFP2 mask. There was evidence that staff removed their mask to have a meal break in the apartments while attempting to maintain a safe distance from residents. However, none of these challenges, obstacles or practice were captured in reviews of infection prevention and control measures or in risk assessments seen. Assessing the challenges and the risk of transmission posed may have identified additional controls that the provider could have explored.

Effective procedures to reduce the risk of the introduction and transmission of infection were needed where residents moved between the centre and home. There were procedures in place that families co-operated with but their timing did not coincide with the residents movement between the centre and home. This meant that the resident could have developed symptoms or have been exposed to infection

after the declaration of wellness was completed.

The person in charge had identified the need to improve the means of escape from one apartment in response to the increasing mobility needs of one resident. The person in charge confirmed that a review had taken place to establish the scope of the work needed. The inspector saw that staff and the resident could exit the rear of the apartment but the extent of the pathway was limited. An accessible pathway to facilitate both mobility needs and wheelchair evacuation was needed to safely support evacuation to a safe location. Consequently, staff were only utilising one of two possible escape route during simulated evacuations. A complete record of all simulated evacuation drills undertaken was not maintained in the fire register. Very little detail was recorded on the drill records. It was not evident how oversight was maintained of simulated drills to ensure all staff regularly participated in a simulated drill.

The inspector saw that an additional emergency light had been fitted in the rear hallway of the apartments. However, the inspector was not assured there was sufficient illumination to the escape route to the front door. This should be reviewed by a competent person.

Records were in place confirming the inspection and testing of fire safety measures such as the fire detection and alarm system at the required intervals.

The inspector again found an inconsistent and fragmented approach to identifying and responding to risk. The person in charge had commenced a review of the risks presenting in the centre, risks as they pertained to each resident and how these risks were controlled. However, there were gaps and matters of risk arising in the centre were not all adequately risk assessed. This did not provide assurance that risk was adequately managed and controlled or escalated as needed in line with the providers risk management policy. For example, in the context of these inspection findings a risk assessment to protect residents from the risk of infection stated that staff should wear a face-mask but did not state what type of mask. There was no link between the occurrence of behaviour related incidents, a risk assessment seen for the risk of behaviour that challenged and the calculation of the residual level of risk. As stated in the previous section of this report, the adequacy and safety of staffing arrangements was not appropriately informed by the robust assessment of any risk presenting. For example, the impact of staffing deficits on the governance arrangements, the appropriateness and safety of the staff sleepover arrangement in one apartment, the possible need for a second staff to support some activities such as swimming for residents and the employment of staff who had yet to complete some mandatory and required training.

The person in charge confirmed that improvement was still needed in the recording of accidents and incidents so that the records supported effective monitoring and analysis. The person in charge told the inspector she had discussed this with staff at a recent staff meeting. The inspector was not assured of the accuracy of incident records seen. Returns to HIQA had reported the administration on three occasions of an as needed medicine. This medicine is prescribed as part of the plan to support a resident to prevent escalation of their anxiety and associated behaviours of

concern. However, there were no recorded behavioural incidents to correspond to the need to administer the medicine as provided for in the medicine protocol. This did not provide assurance that the administration was in line with the protocol. This did not provide assurance as to how record keeping facilitated effective monitoring and oversight.

Regulation 17: Premises

The current location of the main staff office was not suited to the assessed needs and preferences of a resident. This presented difficulties for the resident and for staff.

The coating on some kitchen cabinets was torn and damaged.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The inspector found an inconsistent and fragmented approach to identifying and responding to risk. There were gaps and matters of risk arising in the centre were not all risk assessed. For example, the appropriateness and safety of staffing arrangements. The co-relation between incidents and risk assessments was not adequately demonstrated. The inspector was not assured of the reliability of the incident records seen.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Measures for reducing the risk of the introduction of infection, for the early detection of possible infection and for preventing the spread of infection were not robust. There was no plan to guide staff on how to respond to situations where a resident was reported to have a regular pattern of reporting symptoms that were indicative of COVID-19 or other respiratory tract infections. Reported challenges and obstacles to the wearing of FFP2 masks were not captured in the reviews of infection prevention and control practice or in risk assessments seen. Effective procedures to reduce the risk of the introduction and transmission of infection were not in place where residents moved between the centre and home.

Judgment: Not compliant

Regulation 28: Fire precautions

Works were needed to improve the accessibility of one escape route. A review by a competent person was needed to confirm the emergency lighting provided adequate illumination of escape routes. A complete record of all simulated evacuation drills undertaken was not maintained in the fire register. Very little detail was recorded on the drill records. It was not evident how oversight was maintained of simulated drills to ensure all staff regularly participated in a simulated drill.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had reduced the occupancy of the service and had ceased the requirement for residents to share apartments.

Judgment: Compliant

Regulation 7: Positive behavioural support

Based on what the inspector observed further timely MDT input was needed to support resident's and to guide staff in the management of behaviours that challenged.

A protocol put in place following an incident lacked clear, unambiguous guidance for staff and this had the potential to result in a re-occurrence.

Incident records did not provide assurance that an as needed medicine was administered in line with the administration protocol.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Ralahine Apartments OSV-0005232

Inspection ID: MON-0034457

Date of inspection: 09/03/2022

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Local management structure has been consolidated which includes full time PIC, PPIM and SCW to assist PIC in the day to day management of the DC. 1/04/2022 PPIM has mentorship process in place to support new PIC, which includes formal meetings on fortnightly basis. 1/04/2022 A staff contingency plan has been put in place to address absences at short notice, which eliminates the need for SCW to do frontline work during admin time. 29/04/2022 A contingency plan will be developed to address planned/unplanned absences of a PIC to ensure consistent management and oversight of the service. 29/04/2022 PIC and PPIM will review staffing arrangements in conjunction with HR, other PICs in region and Day Services Manager to identify the core staff that will only work in this DC. 31/07/2022	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training Matrix has been reviewed and updated to clearly identify and include up to date training records for all staff rostered to work in this DC.	

Staff are scheduled to attend or have completed training identified such as medication management, MAPA and IPC.
Training matrix will be subject to ongoing review by SCW and monitored by PIC.

The PIC will ensure that there is a risk assessment in place for new staff who have not been able to complete training due to scheduling.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
PIC has commenced a complete review of all files and records across all apartments to ensure records specified in regulations are in place.

PIC has consulted with person supported in Apt 50 and the person supported is satisfied for the main office to move to Apt 50. Office will be fitted out with secure press and equipment.

Files particular to each apartment will be stored securely in staff bedroom/office of each apartment.

Structure of files will be the same in each apartment so that they are easily accessible and retrievable.

PIC has developed an index of records for the DC to clearly identify what is available on hard copy and soft copy.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Local management structure has been consolidated which includes full time PIC, PPIM and SCW to assist PIC in the day to day management of the DC.

PPIM has mentorship process in place to support new PIC, which includes formal meetings on fortnightly basis.

PIC and PIM will review staffing arrangements in conjunction with HR, other PICs in

region and Day Services Manager to identify the core staff that will only work in this DC.

PIC has consulted with person supported in Apt 50 and the person supported is satisfied for the main office to move to Apt 50. Office will be fitted out with secure press and equipment.

PIC will work from main office at least 3 days a week allowing for clearer oversight, governance and management of the DC.

PPIM will ensure through a quality improvement plan that all data collected is analysed, all systems and processes are reviewed, all audit action plans are progressed and implemented to assure the quality and safety of the service and drive continuous improvement.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
PIC has consulted with person supported in Apt 50 and person supported is satisfied for the main office to move to Apt 50. This office will be fitted out with secure press and equipment.

PIC will consult with Banner Housing, facilities and relevant landlords to assess the remedial work required and ensure such works are completed.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A review of all risks will take place by PIC and PPIM for each apartment to ensure all risks are assessed and any gaps identified are addressed. These include
1. Staff sleep over arrangements /sleep disturbance effecting staff
2. Staff Support for Swimming.
3. Training for New Staff.
4. Correct use of PPE particularly FFP2 masks.
5. Staff working across DC's & impact for IPC.
6. Supporting individual with flu like Covid symptoms and antigen testing.
7. Supporting individual to understand provider role in what she sees as her home.
8. Staff refreshment break and meal times in apartments.

PIC will mentor staff individually and at team meetings on good practice in reporting and recording of accidents and incidents as a way to address inaccuracies and improve quality.

PIC will provide additional briefing to staff to create awareness of the Risk Management process and the link to the Accident and Incident Process (OLIS) what, when and how to report.

Following all reported accidents or incidents on OLIS, PIC will review related risk assessments, amend risk ratings and will ensure that all associated documentation is updated to include actions taken and any new/additional controls implemented are reflected.

PIC will ensure staff understand the medication protocol and the need to record incidents of challenging behavior to validate the administration of as needed medication.

PIC and PPIM will assess the impact of sleep disturbances on staff by collating, analysing and monitoring data on a monthly basis to inform and assure appropriate and safe staffing arrangements.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
PIC will ensure that all staff are aware of the current guidance stating that FFP2 masks must be worn in all health care settings involving patient facing/support.

PIC will monitor staff compliance with this guidance by observation and informal audits when based in the main office of the DC. Any non-compliance will be discussed at team meetings and staff supervision sessions.

All staff have completed You Tube Training on How to Fit Check FFP2 face masks.

Staff will be offered the opportunity to complete Fit Testing of FFP2 masks.

Any issues arising with regard the compliance to the FFP2 mask guidance will be discussed with PIC and PPIM, risk assessed and individual control measures will be agreed and documented.

Risk assessment on the Use of PPE and Good Practice Hand Hygiene has been updated

to provide clear guidance to staff.

Risk assessments have been developed and protocols put in place to guide staff on;
1. Supporting individual with flu like Covid-19 symptoms and antigen testing.
2. Staff refreshment breaks and meal times in apartments.
3. Introduction and Transmission of Infection Between Home & Service

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
PIC will ensure fire drills as per schedule will be completed. This includes a protocol on guidance for simulated fire drills.

All staff will have completed a simulated drill by 30/04/2022 and records of such will be available in the Fire Folder.

PIC will review all records of simulated drills as part of the quarterly reviews and ensure that all staff have completed a fire drill, that adequate records are maintained and the required number of fire drills will have taken place within that quarter. PIC will ensure that any recommendations arising from this quarterly review are implemented and associated documentation is updated.

In consultation with Facilities, plans to improve the means of escape have been developed and a proposal has been submitted to the owners and maintenance company for review and approval. PIC and PPIM will ensure any recommendations/remedial work is completed.

A competent person has been contacted and a date has been agreed to review whether the additional lighting recently fitted at the rear hallway of the apartment has sufficient illumination to assist with a safe escape route to the front door.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
PIC has consulted with person supported in Apt 50 and the person supported is satisfied for the main office to move to Apt 50. Office will be fitted out with secure press and equipment.

PIC will ensure that there is re-engagement with behaviour support to assist team support individual around the new behaviors that have arisen following new living arrangements.

Behaviour Support Plan and Reactive Strategies for staff team will be updated and will be reviewed annually.

PIC will Review and update protocol for use of phone giving clear guidance for staff.

PIC will ensure that all incidents of behavior that challenge are recorded on OLIS, any actions recommended are implemented, related risk assessments are reviewed, risk ratings amended where applicable and all associated documentation is updated to include actions taken and any new/additional controls implemented are reflected.

PIC will ensure staff understand the medication protocol and the need to record incidents of challenging behavior to validate the administration of as needed medication.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/07/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	08/04/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	29/04/2022

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
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	31/07/2022
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	29/04/2022
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (11), (12), (13), and (14) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Not Compliant	Orange	29/04/2022
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	Not Compliant	Orange	29/04/2022

	safe, appropriate to residents' needs, consistent and effectively monitored.			
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 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.	Not Compliant	Orange	31/07/2022
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	29/04/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a	Not Compliant	Orange	22/04/2022

	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.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/07/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/04/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to	Substantially Compliant	Yellow	31/05/2022

	respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/05/2022