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 Haven
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	28 June 2023
Centre ID:	OSV-0005236
Fieldwork ID:	MON-0038714

About the designated centre

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

The Haven is located in a rural area of County Kildare and provides 24-hour residential supports to five adults with an intellectual disability. The centre consists of a large two-storey house with an adjacent self-contained single apartment. In the main house the ground floor consists of a kitchen, utility area, living room, sitting room and bathroom and four bedrooms, one of which is the staff sleepover room/office, with another two bedrooms and a bathroom upstairs. There is also a staff office and games room/staff sleepover room. The apartment contains a kitchen-dining room, a sitting room, a sensory room, bedroom and large bathroom. There is also a spacious garden for recreational use and spacious grounds surrounding the house and apartment. The staff team is made up of social care workers, assistant social care workers, deputy managers, and a person in charge. Nursing input is available from a nurse employed in the wider organisation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 28 June 2023	11:00hrs to 18:00hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

During this inspection, the inspector met with the residents and their support staff team, observed routines and interactions in their home, and reviewed records related to their support structures, goals and wishes, and commentary on their experiences living in this designated centre.

The residents lived in a large countryside house with one resident having their own adjacent apartment building. Each resident had their own private bedroom with adequate space to decorate or personalise their rooms. Residents had access to large living rooms, kitchen and dining space. The centre had exclusive use of a number of suitable vehicles to facilitate community access. While the premises in the main was homely and kept in a good state of repair, some resident areas were not clean on inspection as will be referred to later in this report.

The majority of staff on duty had commenced working in this centre in recent months or were assigned from the relief panel. Staff were observed speaking to the residents with respect and patience. Staff had a generally good knowledge of resident support needs, however there were some examples where inconsistent staff knowledge of certain support structures reflected areas in which the guidance provided to them contained contradictory or incomplete information.

Residents appeared more comfortable in their home and were observed to be more active compared to observations on the previous inspection. Residents were out of bed and ready for their day in the morning, and during the day residents were coming and going from community activities. Some residents had recommended day service one or two days a week to enhance social opportunities, and the provider advised that they were seeking a placement for another resident. One resident had started a new work experience plan one day a week. Some residents were attending community activities such as shopping trips, horse-riding, trampolining, hiking and going to the cinema. The residents being more busy and having improved structure to their day had been attributed as the reason for a decrease in frequency of instances of housemates becoming impatient or aggressive towards each other.

Residents had longer-term goals identified for enhancement of social, recreational or independence opportunities in place. These included objectives such as going on holidays or short breaks, setting up bank accounts, becoming more confident with public transport or accessing formal education. For a number of these identified needs and goals, there was no plan to support their achievement. It was unclear what the staff supports to progress some objectives were, or what the revised plan was for goals which had not been successful. It was not clear how the residents or their representatives were involved in the review of support plans.

One resident was new in the service and was still settling into their home. The provider had conducted an assessment prior to their admission to ensure that the centre had the resources and facilities to support them. The circumstances of their

admission meant that they were unable to meet their new housemates and visit the premises prior to them starting to live in the house, for the provider to be assured of compatibility in a house with a history of issues related to peer compatibility. However, the inspector observed staff providing assurances when they were anxious and supporting them to plan out their day.

The support needs of residents were assessed as part of a quality and safety of care report conducted for the centre in January 2023. In this, the provider had identified requirements for development of activity plans, care plan review, and ensuring assessments were up to date. There was limited evidence available to indicate how feedback and commentary from residents or their family members were captured to contribute to these service reviews.

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

This unannounced inspection was completed as part of a regulatory plan for the designated centre following previous inspection findings in November 2022. The purpose of this inspection was to observe if changes to the personnel and to the management structure, which were in their infancy on the previous visit, had been sustained and had resulted in improvement to regulatory compliance and the quality and safety of resident support.

The service was led by a person in charge who was supported by team lead and deputy team lead roles. Between these managers and out-of-hours contacts, staff had sufficient access to management personnel when required. The majority of staff on duty on the day of inspection were new to the centre. At the time of inspection, the centre was operating with staff vacancies equivalent to three full-time positions, for which the provider advised posts had been offered. The provider had access to a sizable team of relief personnel to fill vacancies in the interim period. Staff commented that they felt supported by the management team and their co-workers, however some commentary indicated that some staff were unsure who their line manager was.

One of the focuses of the recently-appointed management team was to enhance resident activation in the centre, ensure that residents were supported to maintain an appropriate sleep pattern, get more involved in activities outside the house, and become more comfortable living and interacting with each other in the shared house. The provider had demonstrated improvement in this regard, with residents more actively engaged with day services and plans to pursue education and work opportunities. While still an active risk, there had been a reduction in the frequency

of peer-to-peer incidents between residents.

Regulation 21: Records

During the inspection, a number of examples of records were observed to be incomplete, contained conflicting information, or had not been kept up to date. This included information related to resident support needs, risk assessments and controls, and guidance for staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure was clearly defined and facilitated deputation and manager cover when the person in charge was absent. Staff had contacts available for out-of-hours managerial support. The service was resourced with a sizable relief staff panel to cover staffing vacancies until these were filled through an ongoing recruitment campaign.

The provider had carried out a quality and safety inspection in January 2023, in which the provider had identified where the service had improved and where deficits in compliance with regulations, standards and provider policy remained. For areas identified for improvement, the provider had set out actions and target dates for these to be addressed, including areas related to staff training, incident management, support planning and resident information. However, some of the actions following these audits had not been sustained as they were also found on this inspection.

The inspector could not be assured that the systems for overseeing staff practices and premises upkeep were effective. For example, staff guidance and knowledge on residents' assessed needs and supports was inconsistent, and it was unclear how these were being kept up to date. Cleaning schedules were being marked by staff and being signed off by management, when the work had not been done or areas were visibly dirty, which did not provide assurance that these verification checks were occurring consistently.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

A new resident had recently commenced living in this designated centre. The

provider had developed a transition plan for them and carried out a pre-admission risk and impact assessments to be assured that the combination of service users was safe. However, risks such as aggression between people, absconding, and risk behaviours were rated as low or not relevant, which contradicted assessments made elsewhere as well as incidents in recent history which indicated that these were identified risks.

A contract of support was signed between the resident and the person in charge. This contract did not outline the terms, conditions, charges or other details of the residency, with the information fields left unfilled from the original template.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had notified the Chief Inspector of events and practices occurring in the designated centre where required under the regulations.

Judgment: Compliant

Quality and safety

Residents were more active and busy in the community and the provider had successfully reintroduced meaningful opportunities such as preferred day services, some work experience and plans for goals such as holidays and enhanced independence. The residents were observed to have more structure in their day and this had contributed to a reduction on how often incidents occurred in which residents abused or upset each other in the shared house.

Comprehensive assessments of need had been developed which included meaningful identified goals related to enhanced autonomy and independence. However a number of these assessed needs did not have a corresponding support plan to guide staff on how objectives would be achieved. Support structures and risk assessments reviewed contained some incomplete or contradictory information and there was limited evidence of how they were reviewed to reflect serious incidents or new practices. There was limited evidence to demonstrate how residents and their representatives contributed to support plan review and evaluation.

Some areas of the premises were not clean during this inspection, including areas signed off by staff and management as being cleaned. There had been improvement in the premises generally being kept in a state of repair.

Restrictive practices were kept under review to ensure they were continuously

justified and where the provider aimed to phase measures out where the relevant risk had decreased. There was some discrepancy in instructions to staff on the specifics of some restrictive practices and examples in which it was unclear where the impact of measures on other residents was not included in their review. The provider had positive behaviour support plans developed for residents who required them, and while these were quite detailed they had not all been updated to reflect recent incidents and risk controls.

The provider demonstrated a low tolerance of instances of resident abuse, and the inspector found good examples of staff being removed from duty where required, investigations taking place with detailed reports to ascertain facts, and safeguarding plans being developed for longer-term protection of vulnerable adults. While some consistency was required in how engagements with the Health Service Executive and An Garda Síochána were documented, internally the provider demonstrated good practices related to keeping residents safe and learning from instances in which abuse was reported or witnessed.

Regulation 13: General welfare and development

Following the previous inspection, there had been improvement in resident activation in the community. Residents were being provided with opportunities for occupation and recreation. Some residents had recently resumed attendance at day services in line with their assessed needs and wishes. Meaningful goals set out to enhance social, personal and independence opportunities were identified as part of the residents' assessments of need.

Judgment: Compliant

Regulation 17: Premises

Areas of the centre were observed to be dirty. The inspector observed rubbish, tissues, food and debris on the floor and seats of a vehicle which was recorded as cleaned and vacuumed on its last use. In resident bedroom and bathroom areas, the inspector observed a substantial amount of cobwebs, dead flies, spiders and moths on ceilings, corners and light fixtures. The inspector observed excrement on bathroom fixtures and frequently-touched surfaces such as handles and bedroom light switches. These rooms had also been recorded as cleaned, and were signed off by management for the day of inspection. The inspector returned to these rooms later in the afternoon after staff had entered to clean the rooms, and found that the above examples all still remained. Some areas around the house required minor painting or repair work, such as rusted radiators and wall cracks.

Judgment: Not compliant

Regulation 26: Risk management procedures

In the main, risk assessments and control measures were specific to the centre, and its residents and staff, and the staff team recorded clear notes on incidents and accidents occurring in the centre. Some risk assessments and controls were inconsistent with information identified through other means. This included risk assessments whose level of risk was inconsistent with incidents or patterns of incidents identified for the centre and residents, and examples of where risk assessments had not been updated following adverse events or the implementation of new safety measures.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of the most recent comprehensive needs assessments of residents, and the associated care and support plans. The inspector observed a number of areas in which residents were assessed as requiring support, for which there was no corresponding plan or guidance to staff. Examples of assessed needs for which there was no plan included supporting residents to communicate, supporting residents to manage their finances, and supporting residents in their education placements.

Some plans had not been updated following serious incidents, or where the residents' needs or risk controls had changed. In the sample of personal plans reviewed, there was limited evidence to indicate how the participation of the resident or their representative had been optimised. There was limited evidence that support plans were being evaluated to determine their effectiveness in achieving their stated objective. Some resident assessments, risk controls and staff guidance provided contradictory information, which was reflected in discrepancies in staff knowledge when speaking with the inspector.

For some personal development objectives such as new opportunities for recreation, travel or independence, there was limited information on why objectives had not been successful by the target date, and how they would be progressed going forward.

Judgment: Not compliant

Regulation 7: Positive behavioural support

In the sample reviewed of resident assessments and staff guidance on positive behavioural support needs, the inspector found examples of contradictory information which resulted in inconsistent staff guidance. For example, one resident was risk-rated as a green level, low or non-applicable risk for absconding, physical aggression or other risk behaviours, despite them having had recent incidents or a history of same. In another example, staff guidance, including the resident's recent behavioural needs assessment, advised that support staff were not required to wear protective equipment, while other risk controls advised that staff were required to wear bite jackets at all times for their safety. Another resident's behaviour support plan had not been updated to reflect a serious incident in which they exhibited aggressive behaviour presentation which was not previously identified in their support plan.

There were some discrepancies in staff knowledge on the implementation of restrictive practices. For example, staff described one type of physical restraint as being used at all times, while their support plan indicated it to be used only in certain circumstances. For other restraint features, there was limited evidence that the impact on the residents for whom it was not required was considered. Restrictive practices overall were kept under review, most recently in June 2023, to identify the rationale for their continued use, and any strategy to reduce or retire features and practices where the associated risk had decreased.

Judgment: Not compliant

Regulation 8: Protection

The inspector reviewed the records provided for 14 alleged or suspected incidents of resident abuse in the centre in 2023. Where the provider had determined there were grounds for concern, they had conducted an investigation to ascertain the relevant facts and gather evidence from the parties involved. During these investigations, short-term actions were taken to safeguard residents, such as taking staff off-duty or introducing new risk control measures. Lessons learned and outcomes of investigations were used to inform safeguarding plans for the affected persons. While the provider had noted when incidents were reported to the designated officer, there was inconsistency in when input or further query from the Health Service Executive safeguarding and protection team was incorporated into safeguarding plans, and that plans were agreed with the safeguarding and protection team before the matter was closed. There was also inconsistency on when An Gardaí Síochána were advised of confirmed abuse incidents, and the rationale if they had not been informed.

There had been an overall decrease in the frequency of aggression incidents between peers compared to 2022. However, the provider had not followed

appropriate steps to be assured that residents with histories of aggression towards others were safe to start living together, as new peers had met each other for the first time after their admission to live in the centre.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for The Haven OSV-0005236

Inspection ID: MON-0038714

Date of inspection: 28/06/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: 1. The Person in Charge (PIC) in conjunction with the Behavioral Specialist will complete a full review of each Individual's Comprehensive Needs Assessments (CNA's), Individual Risk Management Plans (IRMP's), Personal Plan's and where required Multi-Element Behavioral Support Plan's to ensure all information is accurate and up to date for each Individual. (Due Date: 22 September 2023). 2. Following the completion of the above, the Quality Assurance Department will complete a full review of documentation completed for the HIQA action plan. (05 October 2023). 3. The above points will be discussed with the staff team. (Due Date: 31 August 2023).	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Provider will review all management roles within the Centre. Note: A new Person in Charge (PIC) has been appointed for the Haven. This (PIC) is based full time in The Haven. An NF30A was submitted. (Due Date: 18 August 2023). 2. To strengthen the accountability for work practices carried out in the Centre, the roles and responsibilities of each team member will be reviewed to ensure that. a) There is absolute clarity in relation to the expectations and responsibilities of their roles. b) The Director of Operations (DOO) will go through the Key task list with the Person in Charge (PIC) and the Management team within the Centre to ensure all management are aware of their roles and responsibilities. c) Support Workers to follow the roles and responsibilities as outlined within their Key	

Task Lists. (Due Date: 10 September 2023).

3. The DOO will identify additional training where required to support the PIC, the Management Team, and Support Workers. (Due Date: 30 September 2023).

4. The above points will be discussed with the staff team. (Due Date: 31 August 2023)

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
1. The Director of Operations (DOO) in conjunction with the Admission, Discharge and Transition (ADT) Manager and Senior Behavioral Specialist will complete a full review of ID411's preadmission documents. Following this review any learnings will be shared with relevant members of the ADT committee and key personal within the Organization. (Due Date 09 September 2023).

2. The Person in Charge (PIC) will complete a review of all Individual's Contract for Provision of Services. (Due Date: 09 September 2023)

3. The PIC will complete a review of Key working sessions and Service User forums completed prior to and after ID411's move to the Centre. (02 September 2023).

4. The Designated Officer will be assigned to the Centre monthly to review all "active" safeguarding plans. Additionally, the Designated Officer will meet with the Service Users, if required, in relation to any safeguarding concerns. Minutes will be completed for these meetings and shared with the staff team. (Due Date: 06 October 2023).

The above points will be discussed with the staff team. (Due Date: 31 August 2023)

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The Area Director of Operations (DOO) to complete a review with the maintenance department and schedule set for completion of required works identified in the inspection.
Note: The review was completed and planned maintenance works scheduled which are all due to be closed by 31 August 2023.

2. The Person in Charge (PIC) shall conduct a review of the systems in place regarding the management / overview of maintaining Premises in the Designated Centre to ensure that.
a) A review of the Centre and its layout and environment is checked daily, and any maintenance or repairs are scheduled and addressed.
b) Any maintenance or repairs required are scheduled and addressed in a timely manner.
a) The Person in Charge or in their absence a member of the management team to send daily assurances to the Director of Operations (DOO) on hygiene within the Centre and

any outstanding maintenance jobs. Note: This was implemented on 30 June 2023 and is an ongoing task. The above points will be discussed with the staff team. (Due Date: 31 August 2023)

Regulation 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: 1. Nua's Training Department will provide further training and development to the PIC and the management team in risk assessment and the management and ongoing review of risk. (Due Date: 15 September 2023). 2. The Person in Charge (PIC) in conjunction with the Behavioral Specialist will complete an additional of review of all Incidents within the Centre during 2023 to ensure that all identified risks and behaviors of concern have been documented and appropriately risk assessed. (Due Date: 23 September 2023). 3. The PIC shall complete a full review of all Residents Individual Risk Management Plans (IRMP's) to ensure all controls are appropriately captured documented. Following this the PIC will ensure they have appropriate systems in place for the ongoing monitoring and reviewing of IRMP's. (30 September 2023). The above points will be discussed with the staff team. (Due Date: 31 August 2023).	

Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: 1. The Person in Charge (PIC) in conjunction with members of the MDT team will complete a full review of each Service Users Comprehensive Needs Assessments (CNA's) to ensure that all information in relation to assessed needs is captured. (Due Date: 30 September 2023). 2. The PIC in conjunction with the Behavioral Specialist will complete a full review of each Individual's Personal Plans including their Monthly Outcomes and planned goals. (Due Date: 30 September 2023). 3. Plans are to be reviewed where appropriate by multi-disciplinary and to note the effectiveness of same when completing the review.(Due Date: 30 September 2023). The above points will be discussed with the staff team. (Due Date: 31 August 2023)	

Regulation 7: Positive behavioural support	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Positive	

behavioural support:
1. The Person in Charge (PIC) will review the guidance and behavioural definitions within the Multi-Element Behaviour Support Plans with the Senior Behavioural Specialist, to provide guidance on management of behaviours. (Due date: 08 September 2023)

2. The Person in Charge in conjunction with the Behavioral Specialist will complete a full review of each Individual's Comprehensive Needs Assessments (CNA's), Individual Risk Management Plans (IRMP's), Personal Plan's and where required Multi-Element Behavioral Support Plan's to ensure all information is accurate and up to date for each Individual. (Due Date: 30 September 2023).

3. The Person in Charge in conjunction with the Behavioral Specialist shall complete a review of all Restrictive practices within the Centre to ensure the least restrictive restraint is used for the shortest possible duration in line with national policy. (Due Date: 15 September 2023).

The above points will be discussed with the staff team. (Due Date: 31 August 2023)

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The Person in Charge (PIC) in conjunction with the Director of Operations will complete a review of all Individuals Impact Assessments. (Due Date: 31 August 2023).

2. The PIC, in conjunction with the Designated Officer, will continue to complete reviews of all 'active' safeguarding plans in the Centre to ensure that all control measures in place are adequate and sufficient to maintain quality and safe care to the Service Users and that they reflect the staffing levels and arrangements in place in the Centre. (Due Date: 31 August 2023).

3. There is a Centre Specific Safeguarding Register in the Centre. This continues to be reviewed and updated by the PIC following any safeguarding concerns.(Due Date: 06 October 2023).

4. The Designated Officer will be assigned to the Centre on a monthly basis to review all "active" safeguarding plans. Additionally, the Designated Officer will meet with the Service Users, if required, in relation to any safeguarding concerns. Minutes will be completed for these meetings and shared with the staff team. (Due Date: 06 October 2023).

5. The Designated Officers will attend the monthly staff meetings to provide further assistance and education on safeguarding plans and measures implemented in the Centre. (Due Date: 12 October 2023).

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	31/08/2023
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	22/09/2023
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	30/09/2023

Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Substantially Compliant	Yellow	09/09/2023
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	09/09/2023
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.	Not Compliant	Orange	30/09/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in	Not Compliant	Orange	30/09/2023

	accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/09/2023
Regulation 05(6)(b)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.	Not Compliant	Orange	30/09/2023
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a	Not Compliant	Orange	30/09/2023

	review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	30/09/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/09/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used,	Substantially Compliant	Yellow	30/09/2023

	such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/09/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/09/2023