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:	Edencrest & Cloghan Flat
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	06 and 07 July 2023
Centre ID:	OSV-0005487
Fieldwork ID:	MON-0038765

About the designated centre

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

Edencrest and Cloghan flat provides full-time residential care and support to adults with a disability. The designated centre comprises of a six bedded bungalow and a one bedroom flat located within a campus setting operated by the provider. Residents in the bungalow have their own bedroom and have access to a small kitchenette, dining room, two sitting rooms, clinic/visitors room and bathroom facilities. Cloghan flat provides self contained accommodation with a bedroom, bathroom, kitchen and living room. Meals are prepared and cooked in a centralised kitchen on the grounds of the campus and delivered at specific times throughout the day. The centre is located in a residential area of a town which is in close proximity to amenities such as shops, leisure facilities and cafes. Residents are supported on a 24/7 basis by a staff team of both nurses and health care assistants.

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
Thursday 6 July 2023	14:20hrs to 19:15hrs	Angela McCormack	Lead
Friday 7 July 2023	09:30hrs to 13:55hrs	Angela McCormack	Lead

What residents told us and what inspectors observed

This inspection was carried out to monitor compliance with the regulations and to follow up on actions since the last inspection by the Health Information and Quality Authority (HIQA) completed in October 2022. The inspector found that residents were provided with person-centred care and support and that the centre met residents' needs. However, there were gaps in the monitoring of some practices in the centre which required improvements. This will be elaborated on in the next sections of the report.

The inspection was completed over two half days. The inspector met with five of the six residents, staff members and the person in charge during the inspection. One resident was in hospital at the time of inspection and therefore the inspector did not get to meet with them. However, all other residents who lived in the centre were met with throughout the inspection. In addition to discussions with various residents and staff, the inspector observed the interactions and reviewed documentation in order to establish the lived experiences of residents in the centre.

On arrival to the centre on the first afternoon of the inspection, the inspector met with two residents who were relaxing in the sitting-room with staff. Residents greeted the inspector in their own way and they appeared happy and relaxed. This was observed through their facial expressions and interactions with staff. During the remainder of the evening the inspector got the chance to meet the other residents living at the centre.

Some residents were non-verbal; however they interacted with the inspector through gestures and facial expressions and responded to questions asked. Some residents were waiting further assessments from speech and language therapy (SLT) to assess their communication preferences. There was a box of objects of reference observed in the office, which staff said was being used for one resident. Staff were waiting for training to be completed which they said would further aid them in supporting residents with various communication needs.

One resident spent time speaking with the inspector. They spoke about interests that they had and activities that they enjoyed doing. They spoke about holidays that they had gone on and plans for another holiday later in the year. They spoke about their week and about how they had started a new job recently that they enjoyed. They appeared relaxed and content in their home and with staff supporting them.

Through discussions and documentation review, it was found that residents were provided with, and offered, activities of interest to them. These included; swimming, 'spa' days, day trips, holiday stays and going to concerts. In addition, residents had opportunities for leisure and recreation in their home. There was a spacious garden and communal rooms that had televisions and music players. One room had a large music player and was reported to be a preferred room for one resident to listen to their music. They were observed relaxing and listening to music in this room at

times throughout the inspection.

Throughout the inspection residents were observed coming and going to various activities such as going for walks and bus trips. One resident was facilitated to go on a visit to family on the first afternoon of the inspection. Visitors were welcome to the centre and it was observed that the general practitioner (GP) was doing a visit to one resident on the second day of inspection. Residents were observed relaxing in their homes also, and they appeared comfortable and relaxed in their environment and with staff. Staff spoken with felt that residents had a good quality of life and that there were enough staff on duty to meet residents' individual needs.

Residents' meetings occurred weekly where discussions on various topics occurred such as; complaints, rights, and fire safety. Complaints made by residents were found to be listened to. However, one complaint of a safeguarding nature made by a resident was not identified as a possible safeguarding concern, and therefore the safeguarding process had not been completed. This will be discussed further in the next sections of the report and under Regulation 8: protection.

Residents' meetings were also used as a forum to support residents to make choices on food and activities for the coming week. Staff spoken with said, and some records observed showed, that participation by residents at these meetings could be minimal. Staff spoken with described ways in which non-verbal residents communicated and were offered choices such as the use of objects of reference and pictures; however some staff felt that the use of pictures may not be understood by some residents. As mentioned previously, staff spoke about upcoming training that would support residents' with their preferred communication methods and that would further enable residents to make their preferences and choices understood.

From a walkaround of the centre, it was found that the homes were clean, homely and personalised. The flat where one resident lived alone, had several framed photographs and personal effects throughout their home. The main house was nicely decorated and in general well maintained. However, there were some aspects that required repair and completion. This will be elaborated on under Regulation 17: premises. In addition, the person in charge spoke about plans to change one spare bedroom to another purpose and this was in progress at the time.

Residents had their own bedrooms which were personalised and decorated in line with their interests with various art work, memorabilia and framed photographs. There were ample bathrooms available for residents with level access showers or a Jacuzzi bath, which had recently been replaced. There was a small kitchenette and a separate room for dining in. Main meals were delivered from the campus kitchen and residents also had the option of preparing light meals in the kitchenette. The cupboards and fridge were stocked with a variety of food and snack items. It was noted in documentation that one resident in particular, liked staff to support them cooking their own preferred meals and that this was facilitated.

Overall, the inspector found that residents were supported with their needs and were provided with a person-centred service. The next two sections of this report present the inspection findings in relation to the governance and management in the

centre, and how governance and management affects the quality and safety of the service provided.

Capacity and capability

This inspection found that a gap in the local management structure since January 2023 impacted on some aspects of the oversight arrangements. There were gaps found in the completion of some audits and and some care plans and residents' documentation had not been updated as required. While this did not appear to directly impact on the care residents received at this time, it created a risk that actions required to ensure safe and quality care and support could be missed.

The person in charge worked full-time. They were in their role since August 2022. They had responsibility for one other designated centre located on the campus, and at times had to cover gaps in nursing staff at the other designated centre. The local governance structure consisted of a person in charge and a clinical nurse manager 1 (CNM1) who had a role to support the person in charge in the operational management of the centres. The person in charge reported to a director of nursing (DON) who was also based at the campus. However, since January 2023, there was no CNM1 in place. It was noted in a provider report in March 2023, that cover for this role had been agreed by the provider, but the post had not yet been filled and there was no time-frame for this to occur. The DON was aware of this and reported that they were following up on this. This gap impacted on the oversight and monitoring arrangements and the person in charge reported that it could be difficult trying to complete all required tasks for the centre due to not having a CNM1 in place.

The centre had in place a schedule of local audits to occur at set intervals throughout the year. This included audits in health and safety, restrictive practices, infection prevention and control (IPC), medication, finances, safeguarding and complaints. While most audits were completed in line with the schedule, it was found that the complaints audit had not been completed as required. This had been identified through a provider audit, however had not been fully completed. In addition, there was an audit tool for assessing staff awareness on various aspects of safeguarding. While this audit was completed monthly in line with the schedule, it was found that it not used as effectively as it could be. For example; the audit tool was completed by a member of staff on three staff only in the six months, one of which was the person in charge that the audit was completed with twice. Therefore, this was not being used to assess a good representation of staff who worked directly with residents. Furthermore, it was found through a review of the complaints log that a concern of a safeguarding nature was raised by a resident in August 2022; however this had not been identified as a safeguarding concern at the time and therefore the safeguarding procedure had not been followed. Improvements were required to ensure that all persons supporting residents have the knowledge and awareness to effectively identify incidents of possible abuse, to record them

appropriately, and to ensure that staff know what to do in the event of a safeguarding allegation.

The provider ensured that unannounced visits at six monthly intervals were completed in line with the regulations. In addition, the annual review of the service had been completed and included consultation with residents and their representatives. In general, the provider audits were comprehensive and identified areas for improvement. However, the audits failed to identify areas of non-compliance with regard to the protection of residents nor did it identify that there was a gap in the notification of some restrictive practices to the Chief Inspector of Social Services.

Staffing arrangements and staff training were reviewed as part of this inspection. There was a planned and actual roster in place. The actual roster did not accurately reflect all the staff who were working on the day; however this was addressed by the person in charge when it was brought to their attention. The numbers and skill mix of staff was found to meet with the assessed needs of the residents. However, there was no clinical nurse manager (CNM1) in post at the time of inspection which impacted on some aspects of the management of the centre; this is covered under regulation 23: governance and management. In addition, there were some gaps identified in staff training. The person in charge was aware of this and spoke of plans to address this.

In summary, while the centre had systems in place for oversight and monitoring, the effectiveness of this was impacted at times due to a gap in the local management structure and governance arrangements.

Regulation 15: Staffing

There was a planned and actual roster in place. Some entries on the actual roster were inaccurate for the days of inspection and this was updated and addressed on the day. There were six staff on duty in the main house each day and two staff at night. The inspector found, and staff spoken with verified, that there were enough staff working each day to support residents' needs. While there were agency staff used to cover leave, this was done by a cohort of regular staff to help ensure continuity of care. There was a staffing gap in the local management structure at the time. This is covered under Regulation 23: governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had in place a list of mandatory training that staff were required to complete. In addition, the service had a site specific training plan for staff working in

the centre.There were gaps found in some of the mandatory training programmes as follows:

- Two staff required refresher training in hand hygiene
- One regular agency staff required training in the management of behaviours.
- One staff required refresher training in fire. A date was set for this for the following week.
- Ten staff required 'assisted decision making' training.
- Ten staff required 'clamping' training.

Judgment: Not compliant

Regulation 19: Directory of residents

There was a directory of residents in place which was up-to-date and contained all the information required under the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The following was found in relation to the governance and management of the centre:

- There was a gap in the local management structure since January 2023. This was in relation to cover for the CNM1 post. While it was noted in the provider's audit in March 2023 that the cover for this post was approved, this gap still remained at the time of inspection and there was no time-frame agreed for this to be addressed
- There were gaps in some local audits. For example; the complaints audit had not been completed in line with the provider's schedule of audits.
- The safeguarding awareness monthly audit for 2023 required improvements to ensure it's effectiveness.
- Some staff training was outstanding.
- Some documentation had not been updated as required. For example, some residents' overarching safeguarding plans and intimate care plans had not been updated as required.
- There were gaps in some documentation. For example; the progress notes for some residents' personal plans had not been updated and one annual review meeting did not include the date that the meeting occurred.
- The recording of some incidents required improvements to ensure that staff included all relevant details about what occurred during incidents.
- An incident that involved a resident raising a concern of a safeguarding

nature, while dealt with through the complaints procedure, had not been identified as a safeguarding concern. This had not been identified through any management audits, including provider audits.
- Actions identified to address premises issues had not been addressed in the time frames agreed and identified by the provider.
- Notification of restrictive practices to the Chief Inspector, failed to include one environmental restriction.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose had been reviewed and updated in March 2023 and included all of the requirements under Schedule 1 of the regulations. However, a further review was required as the inspector was informed, and observed, that a plan had commenced to change one spare bedroom to another use.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

While most of the incidents and events that were required to be submitted to the Chief Inspector were completed, the person in charge failed to include one environmental restrictive practice that was in place in one location of the centre since July 2022.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a complaints policy and procedure in place. There was inconsistency in information about the appeals process on the local complaints process and the provider's procedures. This was addressed by the person in charge when it was brought to their attention.

Residents had access to easy-to-read information about complaints, and there was evidence that complaints raised by residents were recorded and followed up to review their satisfaction with the outcome.

Judgment: Compliant

Quality and safety

This inspection found that residents living in Edencrest and Cloghan flat were provided with person -centred care and support. Some aspects of the service provided required improvements to ensure the ongoing protection of residents and in providing more effective supports with residents' preferred communication methods. In addition, some documentation in place had not been reviewed and updated as required.

Some residents did not communicate verbally and while initial assessments had been completed with regard to SLT, further assessments had been recommended and were not yet completed. The inspector was informed that there were plans to provide training to staff in communication methods which aimed to further support residents to use their preferred communication methods. Six staff had received the training, with dates for further training to be set. The person in charge reported that they were attending a meeting after the inspection where this plan would be agreed.

Comprehensive assessments were completed on each resident to assess their health, personal and social care needs. There were care and support plans in place where the need had been identified. In addition, residents were supported to maintain and achieve good health. Where required and recommended, residents were facilitated to access a range of allied healthcare professionals, and supported with any recommendations to enhance their health.

Residents who required supports with behaviours of concern had behaviour support plans in place. These were found to be kept under ongoing review and included clear strategies to guide staff in how to best support residents.

There were a number of restrictive practices in place in the centre affecting various residents for safety reasons. There were protocols and risk assessments in place for their use and to assess that they were proportionate to any risk. Restrictive practice audits were in place to monitor the number of times each practice was used. In general these events had been submitted to the Chief inspector in line with the regulations. However, one environmental restrictive practice, while assessed and kept under review, had not been included on the quarterly notifications since its implementation in 2022.

In addition, the ongoing protection of residents required improvements. As noted previously a complaint made by a resident in August 2022, which detailed a safeguarding concern had not been identified as an allegation of abuse and therefore the safeguarding procedures had not been followed. This concern was reported to have been resolved through the complaints procedures, however there were gaps in the documentation and it was not clear that this had been investigated

appropriately. The person in charge followed up in line with the safeguarding procedures on the day of inspection when it was brought to their attention. However, it was of concern that the management and review of this complaint, including the initial recording of the incident, failed to identify that it was a safeguarding allegation.

In summary, this inspection found that in general the service provided to residents was person-centred and met their health and social care needs. However, improvements in protection, communication and staff training were required to further ensure that the service was safe and to a high quality at all times.

Regulation 10: Communication

Some residents required SLT input to support with their communication preferences. The inspector was informed that there were plans to provide training to staff in communication methods to support residents in their preferred communication methods. Six staff had received the training at the time of inspection, with dates for further training to be agreed and implemented.

Judgment: Substantially compliant

Regulation 17: Premises

The following was found in relation to the premises;

- Kitchen counter top required replacing. This was an action from the previous HIQA inspection and had not been completed in the time frame agreed. The person in charge was awaiting a new time frame for this to be completed.
- Flooring outside one bathroom required repair. This was also an action from the previous HIQA inspection and had not been completed in the time frame agreed.
- Painting around some door frames required completion.
- Some doors required replacement and these were due to be upgraded in the weeks post inspection.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were good arrangements in place to promote and ensure fire precautions in the centre. These included; fire-fighting equipment, containment measures and

checklists for reviewing the fire safety arrangements. Some of the fire doors were due to be upgraded and the relevant fire door personnel were at the centre on the day of inspection to review doors and plan for the completion of this action. This is covered under Regulation 17: premises.

Residents had a personal emergency evacuation plan (PEEP) in place to provide guidance on how to support residents to evacuate from the centre. Fire drills were completed regularly which helped to ensure that residents could be safely evacuated and where required, PEEPs had been updated following a review of fire drills.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that comprehensive assessments were completed on residents' health, personal and social care needs. Care and support plans were developed where required. From a sample of files reviewed it was found that annual reviews occurred to review residents' needs, and these included residents and their representatives as relevant. Some residents declined to attend, and this was noted on the meting notes. Some of the associated documentation required updating to include a date for the meetings, and some progress notes on residents' goals had gaps. This is covered under regulation 23: governance and management

Judgment: Compliant

Regulation 6: Health care

Residents were supported to achieve the best possible health outcomes. Where recommended and required residents were facilitated to attend a range of healthcare appointments, including dexa scans, national screening programmes and various healthcare professionals. In addition, residents were supported to have regular checks with their GPs, as required. There were end-of-life plans in place for residents as appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required supports with behaviours had care plans in place which were up-to-date and included clear and detailed information to guide staff on how to

best support with these behaviours.

Restrictive practices in place were kept under review and assessed as being the least restrictive option for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

Improvements were required to ensure the ongoing protection of residents and staff awareness of safeguarding. The following was found in relation to protection;

- One safeguarding concern raised by a resident in August 2022 had not been identified as a safeguarding concern. While this concern was addressed through the complaints procedure, the safeguarding procedure had not been completed to establish if there were grounds for concern or not.
- There were gaps in the records maintained. For example, the incident record completed by staff did not reflect the alleged concern that was recorded in the daily log notes. In addition, the actions that the person in charge spoke about doing to support the resident had not been clearly documented and it was not clear that the concern had been appropriately investigated. The designated officer made contact with the safeguarding and protection team on the day of inspection and verbally reported this concern, with a preliminary screening completed post inspection.
- Some residents overarching safeguarding plans had not been reviewed as required.
- Some residents intimate and personal care plans had not been updated in line with the provider's requirements for this to be done annually.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents' rights were promoted through ongoing consultation with residents on their day-to-day choices and goals for their future. Residents' meetings were held weekly, where residents were consulted and given information about the centre and choices offered in activities and food. Supports as detailed under Regulation 10: communication, would further enhance residents' methods of making their choices and preferences known.

The provider had in place a Human Rights' Committee who met regularly to review best practice in promoting a human rights based approach.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Edencrest & Cloghan Flat OSV-0005487

Inspection ID: MON-0038765

Date of inspection: 06/07/2023 and 07/07/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The person in charge has scheduled training in the management of behaviours for those staff that required this training and will continue to schedule training as required. Date completed 09/08/23 • The Person in charge will schedule refresher training with emphasis on fire for one staff, hand hygiene for two staff, assisted decision making and clamping training for all staff that require training – Date for completion: 30/09/23 • The Person in Charge will continue to monitor the training matrix on a monthly basis and schedule training as required – Date completed 31/07/23 • The Director of Nursing will continue to monitor the Designated Centres Training Matrix on a Quarterly basis.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Director of Nursing remains in active liaison with the HR Department to address the deficit of the Clinical Nurse Manager 1 within the Designated Centre. The Clinical Nurse Manager 1 position has been accepted and the successful candidate will take up post once a start date has been agreed in conjunction with the HR department. Date for completion: 30/09/23 • The Person in Charge has reviewed and updated the overarching safeguarding plans for all residents in the designated centre. Date completed 31/07/23 • The Person in Charge has commenced a review of all residents personal and intimate care plans to ensure that they have all been updated in line with the providers requirements: Date for completion: 30/09/23 • The Person in Charge has reviewed and updated the Environmental Restrictive Practice	

Protocol and will ensure that all subsequent notifications to the Chief Inspector are in line with regulation. A retrospective notification for the environmental restrictive practice has been submitted to the Chief Inspector. Date Completed 09/08/23
• The Person in Charge has reviewed the audit schedule and completed all outstanding audits with particular reference to the complaints audit Date completed 09/08/23
• The Person in Charge will ensure that all audits are completed in line with the agreed timeframes on the audit schedule. Date for completion: 30/09/2023
• The Person in Charge will ensure that the safeguarding awareness audit is completed more effectively in line with the schedule of audit for the designated centre. Date for completion: 31/08/23
• The Person in Charge will ensure that the residents annual review templates include all information including the date the meeting occurs. Date completed 31/07/23
• The Person in Charge has discussed with all staff the importance of including all relevant details when documenting incidents. This will also be on the agenda for the next staff governance meeting Date for Completion: 31/08/23
• The Person in Charge has completed a preliminary screening and submitted it to the safeguarding and protection team for the incident from August 2022. This has been reviewed by the safeguarding and protection team who have agreed that there were no grounds for concern and have closed the incident. Date completed 09/08/23
• The Person in Charge will ensure that all safeguarding incidents continue to be responded to and managed in line with safeguarding of vulnerable adults at risk of abuse policy – Date completed 31/07/23
• The person in charge has scheduled training in the management of behaviours for those staff that required this training and will continue to schedule training as required. Date completed 09/08/23
• The Person in charge will schedule refresher training with emphasis on fire for one staff, hand hygiene for two staff, assisted decision making and clamping training for all staff that require training – Date for completion: 30/09/23
• The Person in Charge has liaised with the maintenance manager to request an update for the timeframe for the kitchen work top to be repaired and the flooring to be repaired. Date for completion 30/11/23
• The Person in Charge and the Director of Nursing have commenced a full review of the centres Quality Improvement plan to ensure that all actions from audits, Regulatory inspections and provider Inspections are tracked and closed out within the required time frames. Date for completion 18/08/23
• The Person in Charge will ensure that duty roster is reflective of the staff on duty and will continue to ensure that an actual and planned roster is maintained within the centre – Date completed 31/07/23.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Person in Charge in liaison with the Director of Nursing will review the statement of purpose to reflect the change of use for one of the bedrooms within the centre. Date for completion 18/08/23

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The Person in Charge will ensure that all restrictive practices are notified to the Chief Inspector within the required timeframes. A retrospective notification for the environmental restrictive practice has been submitted to the Chief Inspector. Date completed 09/08/23
• The person in charge will ensure that all notifications are submitted to the Chief Inspector within the required timeframes. Date Completed 31/07/23

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• The Person in Charge has reviewed and updated the training matrix to include the communication training that has been identified as a requirement by the speech and language therapist. Date completed: 31/07/2023
• The Person in Charge has agreed a schedule of training dates and topics with the speech and language therapist. Date completed 11/07/2023.
• The Person in Charge will ensure that all staff complete the scheduled communication training identified by the speech and language therapist. Date for completion 31/12/23.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Person in Charge has liaised with the maintenance manager to request an update for the timeframe for the kitchen work top to be replaced and the flooring to be repaired. Date for completion 30/11/23
• The Person in Charge will ensure that the fire doors in the designated centre are replaced in line with the agreed schedule. Date for completion 31/08/23.
• The Person in Charge will ensure that Internal painting works for designated centre is completed. Date for completion 30/11/23.
The Person in Charge and Director of Nursing will review requirement for development of kitchen area in the designated centre. Date for completion 30/11/2023

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Person in Charge has reviewed and updated the overarching safeguarding plans for all residents in the designated centre. Date completed 31/07/23
• The Person in Charge has commenced a review of all residents personal and intimate care plans to ensure that they have all been updated in line with the providers requirements: Date for completion: 30/09/23
• The Person in Charge will ensure that the residents annual review templates include all information including the date the meeting occurs. Date completed 31/07/23
• The Person in Charge has discussed with all staff the importance of including all relevant details when documenting incidents. This will also be on the agenda for the next staff governance meeting Date for Completion: 31/08/23
• The Person in Charge has completed a retrospective preliminary screening and submitted it to the safeguarding and protection team for the incident from August 2022. This has been reviewed by the safeguarding and protection team who have agreed that

there were no grounds for concern and have closed the incident. Date completed 09/08/23

• The Person in Charge will ensure that all actions taken in response to a safeguarding concern are documented to ensure that it is clear as to that the concern has been investigated in line with the safeguarding of vulnerable adults at risk of abuse policy. Date completed 09/08/23

• The Person in Charge will continue to attend the centres bi monthly safeguarding meetings.

• The Person in Charge will ensure that all safeguarding incidents continue to be responded to and managed in line with safeguarding of vulnerable adults at risk of abuse policy – Date completed 31/07/23

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/12/2023
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.	Not Compliant	Orange	30/09/2023
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	Substantially Compliant	Yellow	30/11/2023

	internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	30/11/2023
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	30/11/2023
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	18/08/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which	Not Compliant	Orange	09/08/2023

	a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2023
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	30/09/2023