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:	Railway View & Finnside
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	14 September 2021
Centre ID:	OSV-0005488
Fieldwork ID:	MON-0033901

About the designated centre

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

Railway Finnside provides 24 hour full-time residential support to both male and female residents some of whom have complex support requirements. The centre can accommodate 12 adults and comprises of two detached bungalows which are located on a small campus based setting. There is a centralised kitchen on the campus from which meals are provided to the residents. There is also a day service where residents can attend external to the campus. The campus is within walking distance to a large town in Co. Donegal. Transport is provided to accommodate residents' access to community based facilities. Each resident has their own bedroom. Both bungalows have considerable collective space and spacious gardens. The centre is staffed on a 24/7 basis with a full time person in charge (who is a clinical nurse manager II), a team of staff nurses and a team of health care assistants. The staffing arrangements include four staff on duty each day in one unit and five staff in the other unit. There are two staff on night duty in one unit and three staff on night duty in the other bungalow. Access to GP services and other allied health care professionals form part of the service provided to the residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 - 2015 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
Tuesday 14 September 2021	10:30 am to 7:30 pm	Thelma O'Neill	Lead
Tuesday 14 September 2021	10:30 am to 7:30 pm	Angela McCormack	Support

What residents told us and what inspectors observed

There are two bunaglows in this centre, Railway View and Finnside. On the day of the inspection, there were eight residents in the centre, four residents in Finnside and four residents in Railway View.

On the last inspection, in March 2021 inspectors found the provider was not compliant in nine regulations and substantially compliant in two regulations. This was a follow-up inspection to assess the actions taken by the provider to address the significant risks previously identified in the quality and safety of care provided to residents.

On this inspection, inspectors reviewed the quality and safety of care by observing activities in the centre and by speaking to residents, staff and the management team, and by reviewing documentation. There were some improvements identified from the previous inspection, such as; individualised assessments of need, communication, premises, food and nutrition, protection against infection, and residents' rights. However, significant risks were identified again on this inspection, some similar in nature, and some new risks were also identified. Fire safety was not reviewed on the last inspection, but came to the attention of the inspectors on this inspection, resulting in the inspectors issuing a urgent action to the provider to address the fire safety risks in a timely manner. Inspectors also found the management of risks and staffing to be concern, these issues were identified on the last inspection and had not been adequately addressed. Despite the provider receiving a warning letter post the March 2021 inspection requiring them to address the non- compliances in the centre, the assurances given to the Health Information and Quality Authority(HIQA) in the form of a compliance plan and a Quality Improvement Plan had not been completed.

On arrival to Finnside house on the morning of the inspection, inspectors met with three residents and staff supporting them. Two residents were observed to be getting hand massages by staff in the communal area, and they appeared relaxed and greeted inspectors. One resident was sitting in their chair beside the window and was reported to be expecting a family visit. Residents interacted with inspectors on their own terms. One resident was reported to be having a lie-in in line with their wishes, and one resident was in hospital at that time.

There was one staff nurse working in Finnside who was relocated from another designated centre to cover sick leave, and two health care assistants (HCA), one agency staff and another HCA was supporting a resident in hospital. Therefore, only one staff member working in the centre was an actual Finnside staff member and this was identified during the inspection as a concern in the continuity of care and the delivery of a quality and safe service for residents.

During the walk around of Finnside, fire equipment was observed at various points throughout the building; these included fire extinguishers, fire blankets, and fire

doors. However, the inspector observed one bedroom door was not closing freely, and this risk had been identified by staff during a fire safety check in August, but had not been fixed. Also, the provider had not ensured that appropriate evacuation procedures were in place to safely evacuate all residents in the house in the event of a fire. Staff had identified during a fire drill last July that they could not evacuate the residents with minimum staffing levels. No action was taken to rectify this risk. In addition, a staff member was not familiar with the current evacuation procedures, and when told by the inspector what they were, they said they were not aware there were changes to the evacuation procedure. They also said they had not participated in a minimum staffing drill for over five years. Consequently, inspectors issued a urgent action to the provider to address these fire containment and evacuation risks.

During a walk around of the centre, inspectors observed the centre was homely and tastefully decorated to meet residents' needs and wishes. The residential service was clean and spacious. The main bathroom had a Jacuzzi bath, but the bath had not been used for months, as there was no plug for the bath. This impacted on all residents who liked to have a bath instead of a shower. In particular, the inspector heard one resident being upset and very vocal during a shower, and they told the inspector after their shower they did not like a shower. On review of their behaviour support plan it documented that the resident did not like showers and preferred a bath, as they did not like getting water on their head. The resident was not given an option of a bath, as the bath was not working in the centre. Furthermore, additional psychological support had not been provided to this resident who had recently gone blind, to support them in activities that caused them distress on a daily basis.

The design and layout of the premises ensured that each resident can enjoy living in an safe, comfortable and homely environment; however, the kitchen was not accessible to residents who were wheelchair users due to the lack of space. This inhibited residents independence to access their kitchen facilities. This had been identified on previous inspections and had not been addressed.

Inspectors found on the last inspection that there were three hoists not operational in the centre, this equipment had been repaired and a new ceiling hoist installed in one resident's bedroom. Staff told the inspector of the benefit of having the moving and handling equipment working, in that it reduced the number of transfers for the residents and enhanced their quality of life.

Staff told inspectors that the centralised kitchen had reviewed the meal options since the last inspection and that there were more suitable food options available for residents, who were on a modified diet, particularly for the evening meal. As a result staff told the inspector they noticed two residents had increased the variety of food they were eating as a result of the change in the menu.

In Railway view, staff and residents spoken with talked about residents' plans for the day, with one resident reported to be waiting for their turn to go on the bus and were observed to be sitting with staff in the communal area. The resident became upset during their interactions with the inspector, but did not indicate what was upsetting them. They later appeared more relaxed and were observed to be freely

moving around their home with staff supports. They interacted with the inspector throughout the day coming into the office area at times and looking for the staff nurse as they wanted to look in the medication cupboard, which was something they were reported to request. They were observed to be holding their stomach area at times and were reassured and supported by staff. Throughout the day, residents were observed to be relaxing in their bedroom, in the communal area and going out for bus drives and walks. One resident was reported to have gone to the shops to purchase personal items.

One resident was overheard vocalising loudly in the house, and when the inspector asked staff if they were okay, the inspector was informed that they may be trying to communicate something to the staff supporting them, who may not know what they are communicating because they were unfamiliar staff to them. The inspector observed that the staff nurse was very busy throughout the day both supporting residents with their needs, and supervising and directing agency staff and a student that were also supporting residents with their needs.

Railway View appeared clean, homely and spacious for the four residents who lived there. There were easy-to-read documents, a visual rota and photographs in place around the home. There was a garden area which was nicely decorated with garden furniture, a swing ball set, garden ornaments and planted flowers. The kitchenette area had fridge, freezer and electrical appliances, and was found to be stocked with food and snacks. Residents were noted to be offered beverages throughout the day, and the inspector was informed about the two choices for dinner that day and what one resident had chosen. Throughout the day two residents were observed to be freely moving around the centre supported by staff in line with their assessed needs.

Overall, fire safety, staffing and risk management were a serious concern in this centre. There were some improvements in some regulations, however, inspectors were not assured that these improvements would be sustained due to the staffing crisis in the centre and the provider had not achieved all of the actions they had identified within the timelines agreed.

Capacity and capability

Due to the significant risks identified on the last inspection, the provider, the Health Service Executive (HSE), was issued a warning letter requiring them to bring the centre into compliance with the regulations, or they would be issued with a proposal to cancel the registration of this centre. The HSE responded to HIQA with a robust compliance plan and an overarching quality improvement plan with time bound actions which identified how they would improve the quality and safety of care in the centre. Inspectors found that although there was evidence of some improvement in the centre, there continued to be a high risk to residents specifically relating to the areas of staffing, risk management, fire safety, and governance and management, which continued to impact on the quality and safety of care provided

to residents.

This inspection was conducted to review the actions taken by the provider to address the risks in the centre. On arrival at the centre, inspectors met the new acting director of nursing. They were appointed the week previously to manage Ard Greine Court Campus, which this centre is one of four designated centres. They were familiar with the centre and the care and support needs of the residents and the ongoing regulatory risks in the centre. They were supported by a person in charge who was responsible for managing the day-to- day operations of the centre. The person in charge of the centre was very familiar with the care and support need of the residents. They had the qualifications and skills for the role and responsibility for one centre. They worked four days a week and were due to be supported by a clinical nurse manager 1 (CNM1), but this CNM1 was not yet in post. This was a concern due to the risks identified in the centre, and this was one of the provider's actions to strengthen the governance and management of the centre.

Inspectors reviewed the actions of the last inspection and found that the provider had started to put a lot of the measures in place that were identified in the management improvement plan and the compliance plan. However, inspectors found few of the actions were achieved. Of particular concern, inspectors saw from reviewing the staff rosters and was told that staffing in the centre was at crisis level. The person in charge confirmed to inspector that they had 15 staff on the roster not available for work for various reasons, and they were struggling to maintain staff to work in the centre. They said there was only seven available staff to cover the roster. They said they were heavily reliant on agency staff, and this was a high risk in the centre due to the high care and support needs of the residents. It also had a negative impact on other designated centres as they were having to provide staff from their centres to support Railway View and Finnside. The person in charge told inspectors that they had escalated these risks to senior management and they were seeking support from the human resource department to manage the high level of absenteeism in the centre.

The provider had commenced a programme of staff training. This was in response to the actions identified on the last inspection. Eight staff had completed emergency medication administration training and two staff had completed CPR and emergency responder training. A further six staff were scheduled to complete this training by the end of October. Staff also required training in positive behaviour support, CPR, and communication skills. They also were due to complete training for staff in supporting residents' sexual expression, but this training had not yet commenced.

The provider had implemented a number of changes to the governance structures in the centre, by appointing a new director of nursing and a new clinical nurse manager, however, the CNM1 had not yet commence post. They also resourced a number of new posts which included time specific and part-time posts for multi-disciplinary personnel, such as a speech and language therapist, psychologist and a behaviour support specialist. These resources were found to be a great support to residents and staff in Railway view and Finnside. The provider had also set up a quality and patient safety committee to review accidents and incidents occurring in the centre, and a human rights committee; however, there was no evidence that

these committees were fully operational at the time of the inspection.

Regulation 14: Persons in charge

The person in charge had the qualifications, skills and experience to manage this centre.They were based in Railway view and Finnside and available to provide support to residents and staff as required.

Judgment: Compliant

Regulation 15: Staffing

This centre was in a staffing crisis, due to a high level of absenteeism and this impacted on the quality and safety of care for the residents.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had a training matrix of mandatory training provided in the centre that was required for all staff and which detailed the refresher period. On review of the training matrix and training records, inspectors found that not all staff had received up-to-date training in areas such as positive behaviour management , first aid and communication As well as specific training identified to support residents in expressing their sexuality.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was improvement in the governance and management structures and resources available in the centre, such as; multidisciplinary supports, human resource development and staff training at the centre. However, significant risks to the quality and safety of residents remained in Railway view and Finnside and actions to manage these risks had not been achieved in line with their own quality improvement plan and assurances given to HIQA.

Judgment: Not compliant

Regulation 31: Notification of incidents

All notifications were submitted to HIQA in line with the regulatory requirements.

Judgment: Compliant

Quality and safety

This centre formed part of a campus based setting of eight houses. Inspectors did get the opportunity to meet with eight residents who lived in the two houses during the inspection. Inspectors found that some residents quality of care had not improved since the last inspection despite a review of the assessed needs of the residents. Residents living in this centre had high support needs, both for nursing care and behaviour support. Overall, inspectors found there continued to be significant risks in the quality and safety of care to residents in terms of risks management and fire safety. In addition, assessments of need, health care, managing behaviours of concern, protection, a safe and suitable premise and residents rights all continued to required improvement. Governance and management arrangements continued to require improvement as the majority of these actions had been identified in the last inspection and had not being adequately addressed.

All staff working in the centre appeared friendly and caring to residents. However, when inspectors spoke with staff, many staff were relief or agency staff and were not overly familiar with residents' care and support needs. One staff member said things had improved since the last inspection, they felt residents had more choice around food and social outings, and they had received training in a number of areas in recent months. However, they expressed concerns about the staffing shortages in the centre and the inconsistency of staffing which impacted on the residents' quality of life.

Residents living in this centre had very high nursing support needs and some also had complex behaviours of concern. Since the last inspection, residents' assessments of need and care plans were reviewed and generally reflected their individualised care and support needs. However, some residents' care notes required improvement. Inspectors reviewed one resident's care notes who had previously found to be a high risk of choking, and was in hospital with aspirational pneumonia at the time of the inspection. Inspectors found this resident had two further choking incidents since the last inspection. In one incident, staff had not adhered to the resident's feeding, eating, drinking and swallowing (FEDS) guidelines and the resident was given a cut up sausage instead of a mince moist diet, consequently,

the resident began to choke and had to receive first aid from staff. This resident had a further choking incident since then, and the person in charge told inspectors they had taken the decision to modify the residents diet to a puree diet while they were waiting on a swallowing assessment by the speech and language therapist (SALT). However, on review, the resident's nursing intervention notes were not updated to reflect this change in nutritional needs or supports, and this was a risk due to the inconsistent staffing in the centre.

Residents meals were provided by a centralised kitchen in the campus and improvements were found in the choices in the food menu. Daily monitoring of residents' nutritional intake were maintained in the centre. On review, the inspector found staff were recording residents' food intake, however, they had not identified a risk, where one resident who had frequently refused meals on a regular basis in the month of August. Their weight was not monitored in August or September, and staff spoken with were not aware of this issue. This risk was brought to the attention of the person in charge, they told the inspector the resident had a history of an eating disorder, but on review the person in charge or the inspector could not find the documentary evidence of this in their medical or nursing care notes. There was no nursing intervention plan in place that identified the resident was not eating regular meals and there was no evidence that the resident was under the care of a specialist if they did have a eating disorder. Furthermore, this resident had a fluid restriction chart maintained, and medical records advised staff to maintain the daily fluid restriction of 2,000mls. On review, the fluid balance records maintained between August and September showed the resident had received between 475mls and 1,750mls daily. However, the person in charge did not know why this resident was on a fluid restriction, and there was no documentary evidence in the nursing assessment or intervention plan why this fluid restriction was required. The resident was unable to independently seek additional fluids, if needed, as they were blind and unable to mobilise independently. The person in charge agreed to refer the resident back to their general practitioner for review.

Residents' rights were not fully supported in this centre.This was a campus based setting and the daily routine, meals and staff support were all based around the campus facilities and arrangements. While improvements in person centred planning and accessing social activities were found on this inspection, residents' ability to consent in decisions about their lives, such as who they were living with was limited. Many of the residents' daily activities were dependent on many factors, but primarily inconsistent staffing was the most frequent issue that impacted on residents' choices and wishes not being fulfilled.

Infection control practices at the centre had been enhanced since the last inspection. Staff were adhering to hand hygiene, temp checks and maintaining social distancing were possible. Inspectors visited the two houses separately to ensure physical distancing could be easily maintained. The provider had arrangements in place to isolate a resident should this be necessary in the event of a COVID-19 outbreak.

Since the last inspection, the provider had facilitated residents access to allied health services. Some residents had access to a private speech and language therapist, and

there was evidence of visual schedules of daily activities planned in the centre.There was access to a psychologist and behaviour support specialist, and staff told inspectors how they were supportive to them in managing behaviours of concern. However, there were still high level of incidents even with MDT involvement, such as frequent very loud vocalisations and incidents of self injury. There was also a number of incidents resulting in injury to staff. This situation was further impacted upon as records showed that not all staff had received up-to-date positive behaviour training.

Staff were trained in safeguarding policies and procedures and where concerns of a safeguarding nature were identified, these were followed up in line with the safeguarding procedures. However, the provider had implemented an overarching plan for each resident, but on review, these safeguarding plans did not identify the individual risks or the proactive strategies in place to manage the risks. Also, there was one safeguarding concern reported by a resident last October, and they were still waiting for a social worker to support them and to review their concern. Furthermore, the provider had not implemented recommended staff training to support residents in the area of sexuality, or sexual expression in a supported setting for adults with a disability, as agreed in response to the recommendations of an external safeguarding investigation.

Overall, inspectors found that residents' experiences of the care and support they received differed depending on what house within the centre they lived in, there was considerable more risks identified in Finnside house, and this was similar to the last inspection of this centre. Although, improvements were found in some areas of the designated centre, and the provider had taken measures to bring this centre back towards compliance, these actions were not fully achieved due to the staffing crisis in the centre. The inconsistent staffing in the centre resulted in poor outcomes for residents. These findings of this inspection was communicated to provider representative following the inspection.

Regulation 10: Communication

The inspector found the provider had put appropriate supports in place to facilitate the assessed needs of the residents, such as, assistive technology and aids and appliances. Some staff had training in alternative communication skills

Judgment: Compliant

Regulation 17: Premises

The kitchen facilities in this centre were too small and were not accessible to residents. There was not adequate storage for hoists, and wheelchairs in the centre

as they were observed to be stored in the second sitting room during the inspection. The jacuzzi bath was not working as there was no plug for the bath.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Health risks such as choking were not being appropriately managed in the centre, resulting in serious incidents occurring to residents. Some residents' risks were not appropriately risk assessed or reviewed. In addition, the centre's risk register did not accurately reflect the risks associated with residents behaviours of concern and individual risks, and had not been updated.

Judgment: Not compliant

Regulation 27: Protection against infection

Infection control measures had been enhanced in response to the risk of COVID-19 and reflected current public health guidance. It also included the changes to the isolation unit available to residents in the campus, should the need to self-isolate outside the centre be needed.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had not responded to risks identified in relation to evacuating residents with high support needs with minimum staffing levels. There was not adequate arrangements for maintaining all fire equipment, such as fire doors. The provider also had not ensured that all staff regularly participated in fire drills and were aware of the procedure for emergency evacuation in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Inspectors found some residents nursing interventions plans and risk assessments

had not been updated to reflect residents physical and mental health needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health information and access to health assessments, however, health care professional recommendations were not consistently implemented in the centre. For example, in relation to recommended modified diets, and intimate care practices

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had put measures in place to support staff to manage behaviours of concern in the centre. There was also evidence of ongoing reviews of behaviour support plans to ensure residents' behaviour support needs were being met. Staff were complimentary of the support they had received from the psychologist and behaviour support specialist. However, one resident's behaviour plan was not implemented by staff which resulted in personal distress during intimate care activities.

Although some staff had received training in positive behaviour support, not all staff had up to date refresher training in managing behaviours of concern.

Judgment: Substantially compliant

Regulation 8: Protection

Staff had training in safeguarding and protection, However, resident continued to be at risk of psychological abuse, and staff were at risks of physical aggression in the centre. Inspectors found the overarching safeguarding plans that were in place for residents were non-specific, which created a risk that staff would not be aware of all of the specific safeguarding concerns in the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Inspectors noted that residents had been referred for independent advocacy services to provide information about their rights. Residents rights were being supported in this centre, while improvements in accessing social activities were found on this inspection, residents ability to consent in decisions in their lives was limited. As this was a campus based setting the daily routine and meals, and staff support were all based around the campus facilities and arrangements. Many of the residents daily activities were dependent on many factors, but primarily consistent staff and often their choices and wishes were not fulfilled as a result.

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 - 2015 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	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Railway View & Finnside OSV-0005488

Inspection ID: MON-0033901

Date of inspection: 14/09/2021

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: To ensure compliance with Regulation 15: Staffing the following actions have been undertaken: 1. The Person in Charge has assigned a consistent cohort of staff for the centre supplemented by a regular number of agency staff assigned for the centre to ensure continuity of care for all residents. Completion date: 30/11/21 2. The Person in Charge and the Director of Nursing will continue liaise with HR in relation to absence management. Completion date: 31/12/21 3. The Person in Charge and Director of Nursing will establish a roster to ensure that the centre will be stand alone. Completion date: 31/12/21	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: To ensure compliance with Regulation 16: Training and Staff Development the following actions have been undertaken: 1. A full review of training requirements for the centre has been undertaken. Completion date: 16/10/21 2. The Person in Charge has schedule all outstanding training	

Completion date: 15/11/21
3. The Person in Charge will monitor scheduled training and the training matrix on a monthly basis.
Completion date: 30/11/21

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
To ensure compliance with Regulation 23: Governance and management the following actions have been undertaken:

1. The provider will ensure the CNMI appointed to the centre will be in a position to fully discharge the role.
Completion date: 30/11/21
2. The Person in Charge has assigned a consistent cohort of staff for the centre supplemented by a regular number of agency staff assigned for the centre to ensure continuity of care for all residents.
Completion date: 30/11/21
1. The Person in Charge in liaison with the CNM3 Quality Risk & Service User Safety and each named nurse has commenced a review of all risk Assessments.
Completion date: 26/11/21
2. The Person in Charge in liaison with the CNM3 Quality Risk & Service User Safety has commenced a review of the Risk register to ensure it reflects all risks within the centre.
Completion date: 26/11/21

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The Director of Nursing and Provider Representative are in discussion with the housing association in relation to reconfiguring the layout of the centre. Initial discussions commenced on 23/09/21 and plans have been shared. Further engagement planned to complete the reconfiguration. Completion date: 31/03/22

2. The PIC has undertaken a full review of storage within the centre and taken action to ensure equipment is stored in appropriate spaces. Completion date: 16/10/21

3. The PIC had sourced a supplier to provide a replacement specialised bath and this has been installed in the centre.
Completion date: 19/10/21

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
To ensure compliance with Regulation 26: Risk Management Procedures the following actions have been undertaken:
1. The Person in Charge in liaison with the CNM3 Quality Risk & Service User Safety and each named nurse has commenced a review of all Risk Assessments.
Completion date: 26/11/21
2. The Person in Charge in liaison with the CNM3 Quality Risk & Service User Safety has commenced a review of the Risk register to ensure it reflects all risks within the centre.
Completion date: 26/11/21
3. The Person in Charge will continue to attend monthly Quality, patient safety meetings.
Next scheduled date for meeting 02/11/21
4. Following GP review of the individual's dietary requirements they recommended a change of dietary consistency until a review could be completed by SALT. This was communicated to all staff working within the centre.
Completion date: 17/08/2021
A referral was completed to the Speech and Language Therapy department for a Dysphagia assessment review. Completion date: 17/08/2021

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
To ensure compliance with Regulation 28: Fire Precautions the following actions have been undertaken:

1. The PIC has ensured that a fire drill and evacuation has been completed with minimum staffing and maximum occupancy.
Completion date: 14/09/21
2. The PIC has ensured that the fire policy, contingency plan and individual evacuation plans have been updated following the evacuation/drill on 14/09/21.
Completion date: 15/09/21
3. The PIC has ensured that all staff have been made aware of the updates to the fire policy and contingency plan.
Completion date: 17/09/21
4. The PIC will ensure that all staff within the centre participate in a fire drill on an annual basis.
Completion date: 31/12/21
5. The PIC has ensured that there are arrangements for the maintenance of all firefighting equipment
Completion date: 30/09/21

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
To ensure compliance with Regulation 5: Individual Assessment and Personal Plan the following actions have been undertaken:

1. The PIC and the named nurses have commenced a review of all residents nursing interventions and risk assessments to ensure that they are reflective of the residents current support needs.
Completion date: 15/11/21
2. The PIC will ensure that quarterly audits are completed on all care plans to ensure that they are updated in a timely manner.
Completion date: 31/10/21

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
To ensure compliance with Regulation 6: Healthcare the following actions have been undertaken:

1. The PIC and the named nurses have commenced a review of all residents nursing interventions and risk assessments to ensure that they are reflective of the resident's current health care needs.
Completion date: 15/11/21
2. The PIC will ensure that all named nurses update nursing care plans to reflect changes in care practices
Completion date: 30/09/21
3. The PIC will govern the implementation of healthcare professional recommendations to ensure that they are consistently implemented in the centre.
4. Quarterly audits are completed on all care plans to ensure that they are updated.
Completion date: 31/10/21

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. The Person in Charge has commenced a review all Behaviour Support Plans in liaison with the MDT and CNS in positive behaviour support.
Completion date: 15/11/2021.
2. The Person in Charge has conducted a full review of training requirements in relation to positive behaviour support and has scheduled refresher training as required.
Completion date: 30/11/2021.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
To ensure compliance with Regulation 8: Protection the following actions have been undertaken:

1. The Person in Charge has liaised with MDT, Safeguarding and Protection Team to review all Overarching Safeguarding plans with specific emphasis on risk management.
Completion date: 15/11/2021.
2. The Person in Charge will continue to attend monthly multi-disciplinary safeguarding meetings to ensure further oversight and involvement in relation to safeguarding plans.
Completion date: 31/10/21.
3. The Person in Charge will continue to attend monthly Quality, patient safety meetings to ensure oversight and governance in relation to incident management.
Completion date: Completed 31/10/21

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
To ensure compliance with Regulation 9: Residents Rights the following actions have been undertaken:

1. The Person in Charge and Director of Nursing will work with each resident and their advocates to ensure they understand meal choices in terms of preference.
Completion date: 30/11/21
2. The Person in Charge has ensured that there is a varied choice of food in each house to ensure that residents can make a snack or be assisted in doing so as an alternative to what is provided.
3. The Director of Nursing and Provider Representative are in discussion with the housing association in relation to reconfiguring the layout of the centre. Initial discussions commenced on 23/09/21 and plans have been shared. Further engagement required to

complete the reconfiguration.
Completion date: 31/03/22
1. The Person in Charge assign a consistent cohort of staff for the centre supplemented by a regular number of agency staff assigned for the centre to ensure continuity of care for all residents.
Completion date: 30/11/21
2. The Person in Charge and the Director of Nursing will continue liaise with HR in relation to absence management.
Completion date: 31/12/21
3. The Person in Charge and Director of Nursing will establish a roster to ensure that the centre will be stand alone.
Completion date: 31/12/21

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.	Not Compliant	Orange	31/12/2021
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	30/11/2021

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 17(4)	The registered provider shall ensure that such equipment and facilities as may be required for use by residents and staff shall be provided and maintained in good working order. Equipment and facilities shall be serviced and maintained regularly, and any repairs or replacements shall be carried out as quickly as possible so as to minimise disruption and inconvenience to residents.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the	Substantially Compliant	Yellow	31/03/2022

	designated centre to ensure it is accessible to all.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/03/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/12/2021
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	26/11/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Red	31/12/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for	Not Compliant	Red	31/12/2021

	evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
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.	Not Compliant	Red	31/12/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/10/2021
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that	Substantially Compliant	Yellow	15/11/2021

	resident's personal plan.			
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.	Substantially Compliant	Yellow	30/11/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	30/11/2021
Regulation 08(1)	The registered provider shall ensure that each resident is assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.	Substantially Compliant	Yellow	15/11/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice	Substantially Compliant	Yellow	31/03/2022

	and control in his or her daily life.			